

# External Delegate Referral Request Form

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| **Care Coordinator:**      **Organization:**       | **Phone Number:**      **Care Coordinator Email:**       |
| **Member Name:**      **Member DOB:**       | **Member Medica ID Number:**      **Member Product:**       |
| **Member Primary Care Physician:**       | **Clinic Name/Address:**       |

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| **Personal Care Assistance (PCA) directions****PCA Decrease:*** **Did the member choose other services/supports as an alternative to assessed units/hours of the completed PCA Assessment by initialing #2 in Section 5 on Page 6 of the Supplemental Waiver PCA Assessment and service plan? Yes** [ ]  **No** [ ]
* **NOTE: If member did not choose reduction to fit within EW budget, CC must begin DTR process**

 **PCA Increase:*** **Did PCA units increase by 8 or more units per day from previous authorization? Yes** [ ]  **No** [ ]
	+ **The current PCA assessment must accompany referral request.**
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**Service Authorization**

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| Service Description/ Code | Servicing Provider Name, Address Phone and FaxTax ID (if known) | Units(hrs/days/wks/mths) | Cost | Start Date | End Date |
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***Comments:***

**All external delegate referral request forms are to be emailed to:** [**referralrequest@medica.com**](file:///%5C%5CCorp%5CFS%5CCorpShared%5CGOVTPROG%5CCare%20Coordination%20Products%5CCCP%5CCCP%20folders%5CSpecial%20Needs%20Plans%20Admin%5CClinical%20Oversight%20team%5CClinical%20Managers%20MCS%5CPCA%5CPCA%20Assessments%208%2B%20unit%20increase%5Creferralrequest%40medica.com%20)

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