Behavioral Health Provider Initiated Notice - Adverse Action

(Please Print All Information)

Provider Name: ________________________________ Date of Request: _________________

Address: _________________________________, City __________________, TN Zip Code: ________

Telephone: _______________________ Fax: _____________________

Contact Name: ___________________________ Telephone: ___________________ Ext _____

Attending Physician/Treating Practitioner - Name/Credential: _________________________, ________

Enrollee Name: ________________________________ **MCO/BHO**: ☐ TennCare*Select* ☐ BlueCare Tennessee ☐ UHCCP (United) ☐ AmeriGroup

SSN: ____________________ DOB: _________________ PRIORITY: _______ ☐ N/A

Address: _________________________________, City __________________, TN Zip Code: _________

Telephone: _______________________

Admission Date: _______________ **OR Referral Date**: _______________

Discharging Level of Care:

☐ Inpatient psych/dual ☐ Supervised Residential ☐ CTT ☐ CCFT ☐ PACT

☐ Inpatient Detox ☐ PHP/Psych ☐ Tennessee Health Link

☐ Inpatient Rehab ☐ PHP/A&D ☐ Medication Management

☐ Sub-acute ☐ IOP/A&D ☐ Outpatient Therapy

☐ Residential Treatment ☐ IOP/Psych ☐ Other Outpatient: __________________

Date of Anticipated Adverse Action: _______________

Request For[1] ☐ Delay ☐ Suspension ☐ Reduction ☐ Discharge/Termination

☐ AMA (● **STOP HERE**. No further information is needed. Go to last [staff name/signature] field.)

☐ Transfer - Same LOC: Provider Name _____________________ For LOC Type: _______________ (● **STOP HERE**)

If **Delay or Suspension**, service will be available (mm/dd/yy): _____________ Time: ___ : ___ ☐am ☐pm

Explain action being taken to remedy access problem: ____

____

____

____

[1] **A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension of: Any behavioral health service for a priority enrollee; any inpatient psychiatric 24 hour or residential service; Any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available. When required, written notice must be provided to an enrollee at least two (2) business days in advance of the proposed action.**

If Reduction, state how often will the consumer be seen: ____

For ANY Adverse Action, provide reasons for the proposed action—*based on specific facts that are personal to the Enrollee*—as to why the Enrollee no longer meets medical necessity criteria:

____

____

AND, list the specific clinical documentation used to support your decision (include dates of service):

____

____

☐ **DRAFT discharge summary attached** **– or –** ☐ **Discharge plan as follows:**

Recommended Level of Care:

☐ Inpt Rehab ☐ PHP/Psych ☐ CTT ☐ CCFT ☐ PACT

☐ Sub-acute ☐ PHP/A&D ☐ Tennessee Health Link

☐ Residential/Psych ☐ IOP/A&D ☐ Medication Management

☐ Supervised Treatment ☐ IOP/Psych ☐ Outpatient Therapy

☐ Other Outpatient, specify: _______________

☐ Discharge to Jail (● **STOP HERE.** Go to last [staff name/signature] field.)

Aftercare Appointments:

Provider Name / Address / Telephone Number Service Type / Practitioner Name	Appointment Date/Time
Name: ________________________ T: _______________ Street: _______________ City: ____________ ST: _____Zip Code: ______ Service: _________________ Practitioner: ____________________	___________ ____:____ ☐am ☐pm
Name: ________________________ T: _______________ Street: _______________ City: ____________ ST: _____Zip Code: ______ Service: _________________ Practitioner: ____________________	___________ ____:____ ☐am ☐pm
Name: ________________________ T: _______________ Street: _______________ City: ____________ ST: _____Zip Code: ______ Service: _________________ Practitioner: ____________________	___________ ____:____ ☐am ☐pm

Name: ________________ T: ____________ Street: __________ City: ________ ST: ____Zip Code: _____ Service: ____________ Practitioner: ______________	__________ ____:____ ☐am ☐pm
Name: ________________ T: ____________ Street: __________ City: ________ ST: ____Zip Code: _____ Service: ____________ Practitioner: ______________	__________ ____:____ ☐am ☐pm

Effective date of discharge plan: ______________

The information above is correct to the best of my knowledge. I give my permission for the MCO/BHO to notify the member of this information on my behalf.

Staff Name/Credential (printed): ______________________ **Title**: ____________

Staff Signature: ______________________________ **Date**: __________

Please fax this form to the appropriate TennCare plan:

UHCCP (United)
1-888-291-2615

AmeriGroup
1-866-920-6006

BlueCare Tennessee / TennCare*Select*:
1 -800 – 859-2922