**Authorization for Termination of Health Services Form**



|  |  |
| --- | --- |
| Responsible insured party name:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of member being terminated:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Account number:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Member address:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Member date of birth: \_     \_\_\_\_\_\_\_\_\_\_  Member group #: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member ID #: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Clinic location:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Clinic phone number:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic contact person:  \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Note: If a provider following the Medica policy terminates treatment of a member, the termination cannot extend to other Medica members of that household.* | |
| **Account Activity:**  \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

First date of service Last date of service

**Reason for termination of care:**

|  |  |
| --- | --- |
| Inability to agree on a course of treatment | Unpaid copayments or co-insurance |
| Outstanding/unpaid bills | Consistently misses scheduled appointments |
| Uncooperative or abusive behavior toward provider or provider’s staff | Other, please explain: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

**Notification letter to patient attached:**  Yes No

**30-day corrective action followed:**  Yes No

|  |  |
| --- | --- |
| **Ongoing care issues:**  Yes  No | **Availability of provider issues:**  Yes  No |
| If yes, please explain: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Provider Signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Provider Name:**  **\_\_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**FAX to 952-992-3270**

Providers should refer to the [Medica Provider Administrative Manual](https://www.medica.com/providers/medica-administrative-manual/provider-responsibilities/termination-of-health-services-by-a-provider) for more information on the provider termination of health services process.