**Authorization for Termination of Health Services Form**



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| --- | --- |
| 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.