

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 /VO
 VSHP/VO AmeriChoice AmeriGroup

SSN: ____ - ____ - ____ DOB: ____/____/____ CRG/TPG: ____ N/A

Address: _____, City _____, TN Zip Code: _____

Telephone: (____) ____ - ____

Admission Date: ____/____/____ OR Referral Date: ____/____/____

Discharging Level of Care:

- | | | |
|--|---|--|
| <input type="checkbox"/> Inpatient psych/dual | <input type="checkbox"/> Supervised Residential | <input type="checkbox"/> CTT <input type="checkbox"/> CCFT <input type="checkbox"/> PACT |
| <input type="checkbox"/> Inpatient Detox | <input type="checkbox"/> PHP/Psych | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Inpatient Rehab | <input type="checkbox"/> PHP/A&D | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Subacute | <input type="checkbox"/> IOP/A&D | <input type="checkbox"/> Outpatient Therapy |
| <input type="checkbox"/> Residential Treatment | <input type="checkbox"/> IOP/Psych | <input type="checkbox"/> Other Outpatient: _____ |

Date of Anticipated Adverse Action: ____/____/____

Request For¹ 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: _____
(●)

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

Explain action being taken to remedy access problem: _____

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

¹ For **inpatient** levels of care, this form must be submitted one (1) business day prior to the proposed adverse action date. For **outpatient** levels of care, this form must be submitted eight (8) calendar days prior to the proposed adverse action date.

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:

- | | | | | |
|---|------------------------------------|--|-------------------------------|-------------------------------|
| <input type="checkbox"/> Inpt Rehab | <input type="checkbox"/> PHP/Psych | <input type="checkbox"/> CTT | <input type="checkbox"/> CCFT | <input type="checkbox"/> PACT |
| <input type="checkbox"/> Subacute | <input type="checkbox"/> PHP/A&D | <input type="checkbox"/> Case Management | | |
| <input type="checkbox"/> Residential/Psych | <input type="checkbox"/> IOP/A&D | <input type="checkbox"/> Medication Management | | |
| <input type="checkbox"/> Supervised Treatment | <input type="checkbox"/> IOP/Psych | <input type="checkbox"/> Outpatient Therapy | | |
| <input type="checkbox"/> 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: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm

Name: _____ T: (_____) _____ - _____	____ / ____ / ____
Street: _____ City: _____ ST: _____ Zip Code: _____	____:____ <input type="checkbox"/> am
Service: _____ Practitioner: _____	<input type="checkbox"/> 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:

AmeriChoice 1-888-291-2615

AmeriGroup 1-866-920-6006

TennCare Select / VSHP / Value Options

East: 1-800-859-2922

West: 1-866-320-3800

TennCare Select: 1 -800 – 859-2922

