COMMUNITY HEALTH PLAN of Washington™

FAX: (206) 652-7067

Notification Form for Change in WISe Services

CHPW Member ID: _____

Member Name: _____

Member Date of Birth: _____

Requesting Referral Source: _____

ICD Diagnosis Code(s): _____

Requested Dates of Service: _____

Service Requested: Wraparound with intensive Services (WISe) Program

Type of and Reason for Change in WISe Services and Outcome:

Not Approved

☐ ___ Denial for Program (CANS) ☐ ___ Termination of Services ☐ ___ Reduction in Services ☐ ___ Suspension of Services

Approved

☐ ___ Approved for Program ☐ ___ Graduated ☐ ___ Member Chose to Leave WISe ☐ ___ Ongoing Service Request

Provide an explanation for the change in services or specific reason for denial:

_____

_____

_____