COMMUNITY HEALTH PLAN of Washington™

Fax: (206) 652-7067

Notification Form for Change in WISe Services

MCO Member ID: _____

Member Name: _____

Date of Birth: _____

WISe Provider Agency: _____

Provider Contact Person: _____

Provider Contact Phone Number: _____

ICD Diagnosis Code(s): _____

Date of Enrollment or Denial: _____

Type of and Reason for Change in WISe Services and Outcome: Click here to enter text.

Approved/Other Reason: (Internal MCO Process)

☐ Approved for Program

Not Approved: (Internal MCO Process)

☐Denial of Program (CANS)— the decision not to offer an intake or a decision by the Managed Care Entity (MCE), or their formal designee, not to authorize covered medically necessary Medicaid mental health services.

☐Termination of Services— a decision by a MCE, or their formal designee, to stop the previously authorized covered Medicaid mental health services. A decision by a provider to stop or change a covered service (in the Individualized Service Plan) solely based on clinical judgment is not a termination.

☐Reduction in Services— is the decision by an MCE, or their formal designee, to decrease the amount, duration, or scope of previously authorized covered Medicaid mental health services. The decision by a provider to decrease or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a reduction.

☐Suspension of Services— is the decision by a MCE, or their formal designee, to temporarily stop previously authorized covered Medicaid mental health services. The decision by a provider to temporarily stop or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a suspension.

Please provide a detailed explanation for the change in services or specific reason for denial:

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