# External Delegate Referral Request Form

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| **Care Coordinator (CC):**  **Delegate:**  **CC Supervisor:** | **Phone Number:**  **Care Coordinator Email:**  **Supervisor Email:** |
| **Member Name:**  **Member DOB:** | **Member Medica ID Number:**  **Member Product:** |
| **Member Primary Care Physician:** | **Clinic Name/Address:** |

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| **Personal Care Assistance (PCA) directions**  **PCA Decrease:**   * Did the member choose other services/supports as an alternative to assessed units/hours of the completed PCA Assessment by initialing #2 in section 5 on page 6 of the Supplemental Waiver PCA Assessment and service plan? **Yes**  **No** * **NOTE: If member did not choose reduction to fit within EW budget, CC must begin Denial, Termination, Reduction (DTR) process**   **PCA Increase:**   * Did PCA units increase by 8 or more units per day from previous authorization? **Yes**  **No**      * The current PCA assessment **must** accompany referral request. |
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**Service Authorization**

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| **Service description and HCPC code** | **Servicing Provider Name, Address, Phone, Fax, and Tax ID (if known)** | **Units**  **(hours/days**  **weeks/months)** | **Cost** | **Service Start Date** | **Service End**  **Date** |
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***Comments:***

**\*All external delegate referral request forms are to be emailed to:** [**referralrequest@medica.com**](file:///\\Corp\FS\CorpShared\GOVTPROG\Care%20Coordination%20Products\CCP\CCP%20folders\Special%20Needs%20Plans%20Admin\Clinical%20Oversight%20team\Clinical%20Managers%20MCS\PCA\PCA%20Assessments%208+%20unit%20increase\referralrequest@medica.com%20)

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