Notice of Recommendation for Action Form Instructions

General instructions:

- Notice of Recommendation for Action Form must be used to communicate to SCHA a denial, termination, or reduction of the following services:
  - ***SeniorCare Complete and MSC+ Members:*** All Elderly Waiver services including home care services - home health aide, skilled nursing, therapies (OT, PT, ST), private duty nursing (PDN), personal care assistant (PCA) services
  - ***AbilityCare Members:*** CAC, CADI, TBI, or DD waiver home care services including skilled nurse, home health aide, and therapies (OT, PT, ST)
  - ***PMAP Members:*** CAC, CADI, TBI, or DD waiver home care services including skilled nurse, home health aide, therapies (OT, PT, ST), private duty nursing (PDN), and personal care assistant (PCA) services
- All fields MUST be completed or form will be sent back to the case manager for completion.
- Waiver case managers must notify SCHA within one business day of the discussion they had with the member about a denial, termination, or reduction of the service.

Item	Instructions
Member Information	
1. Date	Date the form was completed.
2. Member Name	First and last name of the member.
3. SCHA ID	Member's health plan identification number.
4. Member Address	Member's address including street address, city and zip code.
5. SCHA Product	Product the member is enrolled. Examples include SeniorCare Complete, AbilityCare, MSC+ or PMAP).
6. Date of Birth	Member's date of birth.
7. PMI	The DHS assigned "Person Master Index (PMI) Number" used in MMIS, also known as Member ID or Client ID.
8. Parent/Guardian Name and Address	Name of the parent/guardian and the address of the parent/guardian including street address, city, and zip code
9. MMIS Service Agreement Authorization #	If the service is currently authorized in MMIS, enter the service agreement authorization number. If the service is not currently authorized enter N/A.
10. Date(s) of Service	Enter the date(s) of service that are being denied, terminated or reduced. If currently authorized enter the date of services that are being denied, terminated or reduced.
Care Coordinator/Case Manager Information	
11. Care Coordinator/Case Manager	Enter the name of the care coordinator/case manager.
12. Phone Number	Enter the phone number of the care coordinator/case manager
13. Primary Care Clinic	Enter name full name of the member's primary care clinic
14. Primary Care Physician	Enter the full name of the member's primary care provider (i.e. Dr. John Smith)

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Recommendation for DTR Information	
15. Recommended Date of Action	Enter the date that you are recommend the service be denied, terminated or reduced.
16. Recommended Action	Check the appropriate box as to what action you are recommending denial, termination, or reduction.
17. Service Provider(s) Name	Enter the service provider's name.
18. Service Provider(s) Address	Enter the address of the office of the service provider.
19. Date of discussion with member or legal representative regarding potential denial, termination, or reduction of service	It is required that the care coordinator/case manager have a discussion with the member/guardian/authorized representative regarding the recommended action. Enter the date of that discussion.
20. Describe the recommended action and reasons why it is being recommended	Enter the description of the service being recommended for denial, termination or reduction and describe the reason why the action is being recommended.
21. Service Code	Check the box for the correct service(s) that is being recommended to be denied, terminated or reduced.
22. Reason Code	Check the box for the most appropriate reason as to why the service is being recommended to be denied, terminated or reduced.