

PROVIDER ASSISTANCE PROGRAM

IMPORTANT INSTRUCTIONS: The purpose of the *Provider Assistance Program* is to help providers coordinate and/or manage the medical care for Mercy Care members at risk. Please complete this form and fax or mail it to member services (fax # 602 351-2313).

Member Name:

Date:

Member ID#:

Provider Name:

Provider Address:

Provider City, State, Zip

Provider Phone Number:

Contact Person

Check box for member assignment (PCPs only) and select primary reason for requesting assistance

Continue Member Assignment

Remove Member From Panel (Include member 30 day discharge notice - *A removal will not be processed without the Member Discharge Letter.*)

Member Issue:

_____ Communication/Deteriorated Relationship (PR01)

_____ Non-Compliant with Medical Care (PR05)
(Case Management Needed)

_____ Excessive No-Shows (PR04)

_____ Possible Drug Seeking (PR06)

_____ Possible Fraud (PR08)

_____ Complex Medical Care/different doctor needed
(PR07)

_____ Other (Describe below) (PROT)

Briefly describe the problem:

Provider Signature

Date:

Office Use only : LOB _____ MSR _____

Changed PCP

Referred for No Show f/u

Referred for Rx restriction

Referred to CM

Completed Fraud Form

No Action Taken