

Minnesota Rule 4685.1010, subpart 2H requires that health plans ensure appropriate handling of situations when a network provider refuses treatment to a member.

If a Medica network provider refuses to continue providing health care services to a member, the provider must notify Medica of her/his intention to discontinue treating the member. Providers should reference Medica's Provider Administrative Manual, Chapter 14, section B, subsection 14, for more information on the provider refusal of treatment process.

## Notification for Termination of Care Form

**Responsible Insured Party Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Member Being Termed:** \_\_\_\_\_ **Account Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
 \_\_\_\_\_

**Clinic Location:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Clinic Contact Person:** \_\_\_\_\_

Individual Names / Family Member Names	Group + Member Number	Date of Birth

**Account Activity:** \_\_\_\_\_ **to** \_\_\_\_\_  
First Date of Service Date of Last Service

**Reason for termination of care:**

- |   |  |
|---|--|
| <input type="checkbox"/> Inability to agree with treatment plan<br><input type="checkbox"/> Outstanding or unpaid bills<br><input type="checkbox"/> Unpaid copayments | <input type="checkbox"/> Violent or abusive behavior<br><input type="checkbox"/> Consistently misses scheduled appointments<br><input type="checkbox"/> Forging of prescriptions<br><input type="checkbox"/> Other, please explain:<br>_____ |
|---|--|

Notification letter to patient attached:      \_\_\_ Yes      \_\_\_ No  
 30-day corrective action followed:          \_\_\_ Yes      \_\_\_ No

<p><b><u>On-going care issues:</u></b>                  ___ Yes                  ___ No</p> <p>If yes, please explain: _____</p>	<p><b><u>Availability of provider issues:</u></b>                  ___ Yes                  ___ No</p>
<p><b>PCP Signature:</b> _____ <b>PCP Name:</b> _____</p>	