Coordinated Care
1145 Broadway Suite 300
Tacoma, WA 9842
Phone: 877-644-4613
Fax: 833-286-1086

PACT Notification and Continuation of Service Request

Please print clearly and fill out entire form *even if the information is documented in attachments*.

Date: ____

Member ID: ____

Member Name: ____

Date of Birth: ____

Requesting Physician or Referral Source: ____________________________________

ICD 10 Diagnosis Code(s) ____

Requested Dates of service: ____

Notification Reason:

Initial Notification   Ongoing Request   Approved for Program   Graduated   Member chose to leave Program

Denial of Program

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

For ongoing services: Please provide treatment plan and cross system involvement