

Notification Form for Wraparound with Intensive Services (WISe) Program

Today's Date (Date of Notification): _____

Member Name: _____

Member ID: _____

Member Date of Birth: _____

WISe Provider Name: _____

WISe Provider Contact Information: _____

ICD 10 Diagnosis Code(s): _____

Date of Denial or Decision to Modify Services: _____

Denial or Decision to Modify Services and Reason for Decision:

- Denial of Program (CANS) A decision not to offer an intake or a decision by the Managed Care Entity (MCE), or their formal designee, not to authorize covered, medically necessary Medicaid mental health services.
- Termination of Services A decision by MCE, or their formal designee, to stop previously authorized, covered Medicaid mental health services. The decision to stop or change a covered service (in the Individualized Service Plan) solely based on clinical judgment is not a termination.
- Reduction in Services A decision by MCE, or their formal designee, to decrease the amount, duration, or scope of previously authorized, covered Medicaid mental health services. The decision to decrease or change a covered service (in Individualized Service Plan) solely based on clinical judgment is not a reduction.
- Suspension of Services A decision by MCE, or their formal designee, to temporarily stop previously authorized, covered Medicaid mental health services. The decision to temporarily stop or change a covered service (in Individualized Service Plan) solely based on clinical judgment is not a suspension.

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