SUBMIT TO
Coordinated Care
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX: 1.833.286.1086

PACT and WISe Notification, Denial and Service Updates

Please print clearly and fill out entire form <u>even if the information is documented in attachments.</u>

Incomplete or illegible forms will be returned.

***Required Fields**

Requested Services in PACT WISe Initial Request Ongoing Request Close Denial Graduate

*Date ______________________

***Member Information**

*Name ______________________

*Date of Birth ______________________

*Patient Medicaid Number ______________________

Requesting dates of services: ______________________

***Provider Information/ Billing Facility**

*Provider Name: ______________________

*Facility Name: ______________________

*Facility: ______________________

***ICD 10 Diagnosis Code(s):**

Primary: ______________ Secondary: ______________ Additional: ______________

For WISe Services: CANS Assessment completed: Meets criteria Does not meet criteria

For ongoing services: Please provide treatment plan and cross systems

Coordinated has occured with:

PCP Yes No Psychiatrist Yes No

Name of PCP: ______________________ Name of Phychiatrist: ______________________

Current or historical behavior health treatment: Yes No

Name of treating Behavioral Health (BH) Provider: ______________________

Parent/guardian agrees with WISe treatment goals: Yes No

Please provide reason for denial/closure

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