

Mental Health Center of Dane County, Inc.
TERMINATION OF TREATMENT FORM

Upon terminating treatment of a client who is a member of the HMO, please complete and return this form to the Mental Health Center Utilization Management Program Care Facilitator by FAX at (608) 280-2707 or by mailing the completed form to: MHCDC UMP Care Facilitator, 625 West Washington Avenue, Madison WI 53703.

Questions may be directed to the Care Facilitator at (608) 280-2702.

MEMBER INFORMATION			
<i>Name — (Last, First, Middle Initial)</i>		<i>Date of Birth</i>	<i>Medicaid ID Number</i>
PROVIDER INFORMATION			
<i>Clinician Name</i>		<i>Practice/Group/Vendor</i>	
<i>Telephone # & Extension</i>	<i>FAX #</i>	<i>Clinician's Billing Credentials</i> <input type="checkbox"/> Bachelors (HN) <input type="checkbox"/> Masters (HO) <input type="checkbox"/> PhD Psychologist (HP) <input type="checkbox"/> APNP (UB) <input type="checkbox"/> Phys Asst (U8) <input type="checkbox"/> MD (UA)	

I have terminated treatment of this HMO Member effective this date:

Date of Member's last appointment:

Reason for termination:

**PROVIDER
SIGNATURE**

Date Signed:

<i>MHCDC Use Only</i>	
Date Received	Date Sent to Claims
Staff initials	Staff Initials