

# Fax

**Date:** Click or tap to enter a date.

**Subject:** **Uncompensated care authorization request**

**To:** **Service Authorization Unit**

**Children’s Mental Health- Case Management**

**Fax:** **(612) 466-9673**

**From:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text.

**Fax:** Click or tap here to enter text.

**Number of pages:** Click or tap here to enter text.

## Message

Provider Instructions:

Complete the form on the following page for Medical Assistance (MA) denials and/or lapses. Be sure to provide all requested information. Incomplete requests will not be processed.

Direct any questions to your assigned contract manager.

Thank you.

**Medical Assistance Denial**

Client name: Click or tap here to enter text.

Date of birth: Click or tap here to enter text.

Service dates/period of uncompensated care: Click or tap here to enter text.

Denial remittance date(s): Click or tap here to enter text.

Reason for denial of payment: Click or tap here to enter text.

**Please attach a copy of the DHS claim denial for *each month* uncompensated care is being requested.**

**Medical Assistance Lapse**

Client name: Click or tap here to enter text.

Date of birth: Click or tap here to enter text.

Service dates/period of uncompensated care authorization request: Click or tap here to enter text.

Date client’s MA became active again: Click or tap here to enter text.

If not reactivated, date MA is anticipated to be active again: Click or tap here to enter text.

MHCP Eligibility Inquiry (270) date and/or Denial remittance date(s): Click or tap here to enter text.

**Please attach a copy of the Minnesota DHS: Minnesota Health Care Programs Eligibility Inquiry (270) and/or claim denial for *each month* uncompensated care is being requested.**