PHYSICIAN CONFIRMATION FORM

For Reductions or Discontinuances of Services Within the LTHHCP

Patient's Name _____ **Date**_____

Date of Birth _____**Physician's Name** _____

CIN# _____**Physician's Fax Number** _____

A Medicaid recipient may request a State fair hearing when a social services district or a long term home health care program (LTHHCP) proposes to reduce or discontinue a service the Medicaid recipient receives within the LTHHCP and the recipient's treating physician disagrees with the proposed reduction or discontinuance of the service.

We are proposing to reduce or discontinue one or more services your patient receives within the LTHHCP. We must know whether you agree with this proposed change. (We are NOT proposing to discontinue your patient's participation in the LTHHCP itself.)

We are proposing that _____
(insert name of service)
be changed as follows:

FROM:_____

_____

_____

TO: _____

_____

_____

BECAUSE: _____

_____

_____

PLEASE INDICATE WHETHER YOU AGREE WITH THIS PROPOSED CHANGE.

☐ I **AGREE** with this proposed change.

☐ I **DISAGREE** with this proposed change BECAUSE (optional)

_____

_____

_____

PLEASE RETURN THIS FORM WITHIN 10 BUSINESS DAYS TO:

_____

_____

_____

TELEPHONE NO:_____

FAX NO:_____

_____ _____

Physician's Signature **Date**