Eligibility Communication Form

Client: _____ Provider: _____

Agency chosen for TCM services: _____

Specific issues, requests, or concerns to note:

Referral source contacted: _____ Date: _____

Attempts to schedule with parent/guardian:

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Unbillable: _____

Approved: Date: _____

Explanation of denial: _____

Appealed:

YES Result of appeal: _____

NO Reason: _____

Services offered to family:

Agency Use:

Approved: Date: _____

Explanation of denial: _____

Provider reimbursed:

Date: _____ Check number: _____