

**TRAUMATIC BRAIN INJURY WAIVER PROGRAM
REQUEST FOR DISCONTINUATION OF SERVICE**

Date: ___/___/_____

SUBMIT ALL REQUESTS TO:

Mail: APS Healthcare, Inc.
100 Capitol Street, Suite 600
Charleston, WV 25301

Fax: 866.607.9903

Member Information:

Name _____

Member Legal Representative if applicable _____

Address _____

Medicaid Number _____ Phone () _____ - _____

REASON FOR REQUEST:

- No Services have been provided for 180 continuous days.
Date of last service ___/___/_____ (required)
- Unsafe Environment: must attach documentation to support request for closure.
- Member No Longer Desires Services: must attach Member's written request with signature.

Requesting Entity _____

Address _____

Mailing Address _____

Phone () _____ - _____ Fax () _____ - _____

Printed Name of Person Making Request

Signature of Person Making Request

Title

Date

Note: If the request is approved by APS Healthcare, Inc., a notification of discontinuation of services will be mailed to the member (or legal representative) and a copy to the Case Management Agency and PPL (if applicable).