

McLaren Medical Group  
**PATIENT DISCHARGE**  
***Prior Authorization***

Patient Name: \_\_\_\_\_

Office: \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance: \_\_\_\_\_

**Discharge from:**

- Physician
- Office
- Network

**Discharge Category:**

- No Show
- Breakdown in provider-patient relationship
- Non-compliance with controlled medicine agreement
- Prescription Fraud
- Behavior
- Other, describe: \_\_\_\_\_

*Supportive documentation to be submitted:*

- Evidence of communication between provider and patient discussing the intent to discharge (this may also be in letter format)
- MAPS report (when applicable)
- Events leading up to discharge decision
- For "No Shows", list of appointments missed in prior 12 months, copy of missed appointment letter (s) along with copy of signed receipt.

**Discharge description:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Name: \_\_\_\_\_

PCP Name, if different: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Manager Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR INTERNAL USE**

Date received in PI Department: \_\_\_\_\_

Comments:  Additional documents requested \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Approved

Compliance Officer Signature: \_\_\_\_\_

Denied

Date: \_\_\_\_\_

Approved via email (attached) Date: \_\_\_\_\_

Sent to Managed Care Date: \_\_\_\_\_