Community Care Associates, Inc.
Case Management Department
Fax 961-3166

Catastrophic / Appeals

Date: _____ **DOB: _____**

Name: _____ **Sub. ID#: _____**

Effective Date: _____ **Date of Service: _____**

Certification #: _____ Original Application Needed? □ Yes □ No

Provider: _____

Concern: _____

_____

Investigation:_____

_____

_____

_____

Case Management Results: _____

_____

_____

Recommendation: _____

_____

_____

Medical Advisor: _____

Case Manager: _____ Date: _____