PerformCARE®

ACT/CTT Medicaid Lapse Notification Form

(Providers should submit this form to PerformCare when a Member's Medicaid eligibility has ended and funding transfer occurred)

Member's Name: _____   MAID#: _____

Member's DOB: _____

Person Completing form: _____ Phone number: _____

Date of Medicaid eligibility termination: _____

Reason Medicaid eligibility termination: _____

Plan to have Medicaid eligibility reinstated: _____

How will Member continue to be funded for services: _____

Current Diagnosis: _____

Current Medications:

Current Treatment Goals:

*Please note, with MA Eligibility termination, Member will be 'discharged' from ACT/CTT authorization via PerformCare. If member's eligibility is reinstated while remaining in ACT/CTT services, please feel free to submit an initial authorization request.

Capital Members: 1-888-722-8646   Franklin/Fulton Members: 1-866-773-7917
Providers: 1-888-700-7370   Fax: 1-855-707-5823
Mailing Address: 8040 Carlson Road   Harrisburg, PA 17112

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