

Close Out Form

- WWHP
- FFHP

Contractor/Location: _____

Clinic Site: _____ Provider Name: _____

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: ____/____/____ (MM/DD/YYYY) Date of Close Out: : ____/____/____ (MM/DD/YYYY)

LOST TO FOLLOW-UP:

Required Actions:

- Phone Calls (3)** Dates: ____/____/____ ____/____/____ ____/____/____
- Certified Letter** Date sent: ____/____/____

Optional Actions:

- Home Visits** Dates: ____/____/____ ____/____/____ ____/____/____

Reason:

- Deceased** ____/____/____ Cause: _____
- Patient compliance issue**
- Unable to locate – Moved:** In-state Out-of-state Out-of-country

Ineligible

- Age ineligible
- AHCCCS
- BCCTP (treatment program through AHCCCS) Eligibility Date: ____/____/____
- Medicare
- Over income
- Patient compliance issue
- Private insurance

Refusal

- Chose to withdraw from program
- Signed refusal letter (attached)
- Verbal refusal – Date: ____/____/____

Last Procedures in Program

- Breast** Date: ____/____/____
- Cervical** Date: ____/____/____
- Colorectal** Date: ____/____/____

Case Manager's Name: _____

Case Manager's Signature: _____

Date: ____/____/____