Print Form

AlohaCare
Aloha is the difference

Notification of Termination
Behavioral Health Treatment

Provider Name:		**Specialty** ☐ MD ☐ DO ☐ PhD/PsyD ☐ LCSW ☐ CSAC ☐ LMHC/LMFT ☐ APRN/NP
If affiliated with a Clinic/Facility, Please Indicate Facility Name:		Office Contact Person:
Phone:	**Fax:**	**Date:**

MEMBER INFORMATION

Member Name:	**Member ID:**	**DOB:**

REASON FOR TERMINATION OF TREATMENT

The above patient has been discharged from behavioral health treatment covered by AlohaCare at our office or facility for the following reasons:

- ☐ Treatment was completed.
- ☐ Patient did not show for three (3) consecutive scheduled appointments.
- ☐ Patient did not respond to follow-up letters.
- ☐ Patient discontinued treatment.
- ☐ Patient declined services after the evaluation.
- ☐ Provider terminated treatment. Reason: _____
- ☐ Patient is no longer insured by AlohaCare.
- ☐ Patient has moved.
- ☐ Patient was referred to: _____ for further services.
- ☐ Patient was referred back to PCP.
- ☐ Patient has died.

Please complete:

1) Last service date: _____

2) Total # of visits used within last authorization period: _____

Provider Signature: _____ Date: _____

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