TEFRA/Katie Beckett

Level-of-Care Determination Routing & Fax Form

DATE SENT: November 15, 2010

TO: **Georgia Medical Care Foundation**
ATTN: TEFRA/Katie Beckett
P.O. Box 105406
Atlanta, GA 30348

Or Fax: 800-716-5358 Pages: of

FROM: *** Insert County Name *** County DFACS
Medicaid Worker's Name: ** Insert Worker Name **
Caseload #: ** Insert Load ID ** Phone:
Email address: ** Insert GroupWise Address**@dhr.state.ga.us
Medicaid Worker's Mailing Address:
** address line 1 **
** address line 2 **
*** City ***, GA Zip

RE: Child's Name: ** insert child's name **
Child's Member ID #: ** insert child's MHN ID **
Child's SSN:

A **complete packet** must be submitted to the GHP/GMCF.

Complete packet **Additional information**

Original DMA-6A (see instructions for completion of form)
DMA Care Plan (see instructions for completion of form)
Therapy Notes, if applicable
Psychological Evaluation, if applicable
IEP or IFSP, if available

Date packet received by GMCF: _____