REQUEST TO REMOVE CLIENT FROM MACSIS

Please complete the following information for the client you wish to have removed from MACSIS.

UCI #: _____ **DOB:** _____ **First 3 letters of last name:** _____

Reason for request:

- ☐ **Client is enrolled in MACSIS and has no claims in the system.**
- ☐ **Client is enrolled in MACSIS and has services in the system but they were not paid in whole or part by public funds.**

Request initiated by:

- ☐ **Client**
- ☐ **Provider :** _____ **UPI #:** _____
  Contact Person: _____ **Phone #:** _____
  Fax #: _____
- ☐ **Board:** _____ **Board #:** _____
  Contact Person: _____ **Phone #:** _____
  Fax #: _____

If Client/Provider initiated, date sent to Board: _____

Date received by Board: _____

Action Taken by Board:

- ☐ **Request denied**
  Comments/reason: _____
  - ☐ **Provider notified**
- ☐ **Request approved. Date sent to State:** _____

Date received by State: _____ **Rec'd By (Staff Initials):** _____

Action Taken by State:

- ☐ **Client deleted**
  Date Deleted: _____ **Staff Initials:** _____
- ☐ **Claims for services that were not paid by public funds were deleted.**
  Date Deleted: _____ **Staff Initials:** _____
- ☐ **Forwarded to Outcomes staff** **Date:** _____
- ☐ **Outcome records deleted:**
  Date Deleted: _____ **Staff Initials:** _____
- ☐ **Notification of action taken sent to Board.**
  Date Deleted: _____ **Staff Initials:** _____