LAKELAND CARE

Together, we build better lives.

Change in Condition Rate Review Request

Provider Name:			
Location:			
Provider Contact Name:		Provider Phone Number:	
Provider Contact Email:			

Member Name:	
Member DoB:	
Current Rate:	
Requested Rate:	

Please provide details regarding the current change in condition that the member is experiencing:

Please provide the date that the change in condition occurred:

Please provide details of the specific changes in care, supervision, and/or support needs provided to the member specific to this change in condition:

Please provide the date that the changes in care, supervision, and/or support were put into place:

Please indicate if the change in condition is temporary or long term (describe anticipated time to recovery, if any), and how long the additional care, supervision, and/or supports are believed to be needed at this level:

Provider Signature:	
By signing or typing my name, I attest this information is accurate to the best of my knowledge.	
Date:	

Please send completed form to networkrelationssupport@lakelandcareinc.com.