MAGELLAN HEALTH SERVICES
Getting Better All the Time™

PM Form 8.5.3
Medical Care Evaluation (MCE) Quarterly Progress Report

Name of facility: _____

DBHS provider ID: _____

Title of study: _____

MEC study period: _____

Submission date: _____

Synopsis of Quarterly Activities and Progress
Findings: **Monitoring results, graphs, etc. (Please attach copies):** **Preliminary conclusions:** **Actions taken to date:**

Signature of QM staff member _____ **Date** _____