

# REQUEST FOR REVIEW OF AUTHORIZATION DECISION

(Form #1 of 2)

Date :	1/30/2015	Time:	2:56 PM
Review of authorization decision in the case of:			
Requested by:			

On \_\_\_\_\_(date), this client's assessment was reviewed by the CMHSPs Access Center to determine if the client's level of need warranted authorization at the requested level of care. The CMHSP did not authorize the requested level of care.

The requestor of this review feels the decision is in error and having discussed this with the utilization review specialist and having received no satisfactory resolution, the requestor formally invokes the review policies and procedures of the CMHSP.

Brief statement of reasons for feeling the Utilization Review Specialist's decision is in error:

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Is the client aware of this request? Yes ☐ No ☐

Does the client concur in the request? Yes ☐ No ☐

Do you affirm that an attempt was made to resolve differences? Yes ☐ No ☐

Signature: \_\_\_\_\_

For CMHSP Administrative Purposes, do not complete:

Date Received by CMHSP		Today's Date	1/30/2015
Date of scheduled reassessment			
Reassessment Team			

**REQUEST FOR REVIEW OF CMHSP AUTHORIZATION DECISION, cont.**  
(Form #2 of 2)

	ORIGINAL SEVERITY	ORIGINAL COMPOSITE	NEW SEVERITY	NEW COMPOSITE
MEDICAL				
EMPLOYMENT/ SUPPORT STATUS				
DRUG ALCOHOL/USE				
LEGAL STATUS				
FAMILY/SOCIAL				
PSYCHOLOGICAL				

Recommendation of Reassessment Team:

Member 1:	
Member 2:	

Outcome:      ☐ Authorized 3 of 3                      ☐ Non-authorized 3 of 3  
                     ☐ Authorized 2 of 3                      ☐ Non-authorized 2 of 3

Signatures of Reassessment Team: 1. \_\_\_\_\_ 2. \_\_\_\_\_

Client Signature: \_\_\_\_\_ Agree ☐ Disagree ☐

Appeal Requester: \_\_\_\_\_ Agree ☐ Disagree ☐

To Appeal Requester: Do you wish further review by CMHSP?      Yes ☐      No ☐

If yes, all materials should be forwarded immediately.

The original request shall be retained by the person or agency requesting the appeal. Copies should be provided to the client and CMHSP.

Reassessment Team should complete the original and date, and complete their copy and date. A completed copy of the original, when fully finished, should be sent to the appropriate CMHSP on the day of the review.