Claim Number: _____

To be completed by the Hospital

Type of Program

_____ Inpatient

_____ Partial Hospitalization

REQUEST FOR CLAIMS RECONSIDERATION

Facility Name _____

PART I:

Date _____ Name _____CMH Case # _____

Date of Birth _____ Admitting Psychiatrist _____ Unit _____

Admit Date _____ Discharge Date _____ Current/Discharge Diagnosis _____

Attending Physician _____ Hospital Billing Authorization # _____

Admission Authorization # _____

Dates Reconsideration Request is for _____to _____ Dates of Care Currently Authorized to be Billed _____ to _____

PART II: TYPE OF RECONSIDERATION REQUEST

(Check only one)

(1) Denial of Admission

___ Inpatient Hospitalization ___ Partial Hospitalization

(2) Denial of Continued Stay

___ Inpatient Hospitalization ___ Partial Hospitalization

(3) Retrospective Review

___ Inpatient Hospitalization ___ Partial Hospitalization

PART III: RATIONALE FOR RECONSIDERATION

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Check if this is an Expedited Request _____

Signature _____ _____ _____AM/PM

Physician/Psychiatrist Date Time

C060P (Revised 3/9/11)
(Legal/Fin)