CMH Case Number:_____ Claim Number: _____

To be completed by CMH

RECONSIDERATION DECISION

Part I:

Date of Request_____
Admission Authorization # _____ _____Inpatient _____ Partial Hospitalization
Facility_____

Consumer Name _____ Clinical Record #_____

Date of Birth _____ Medicaid # _____

Attending Physician _____ Review Date _____

Admission Date _____ Discharge Date _____ Denied Dates From _____ To _____

Part II: TYPE OF REVIEW (Check only one)

(1) Admission
___ Inpatient Hospitalization ___ Partial Hospitalization

(2) Continued Stay Review
___ Inpatient Hospitalization ___ Partial Hospitalization

(3) Retrospective Review
___ Inpatient Hospitalization ___ Partial Hospitalization

Part III: RATIONALE FOR DECISION

_____

_____

_____

_____

_____

_____

Name of Reviewer and Credentials: _____

Reviewer Signature_____ Date_____

PART IV: PHYSICIAN/PSYCHIATRIC REVIEW (Required only for a Reconsideration Denial Decision)

Summary of Peer Contact _____

_____

_____

_____

_____

_____

_____

_____

Physician/Psychiatrist Signature_____ Date_____

PART V: DECISION

_____ APPROVED
Approved For _____ Days, Beginning _____ and Ending _____.

_____DENIED
Date of Decision_____

Authorizing Signature _____ Date _____
Phone #_____
Fax #_____