Please indicate level of Appeal you are currently filing: ☐ 1 ☐ 2 ☐ 3

If 2 or 3 is checked above, the assigned KCMHSAS appeal number MUST be written here: _____

Provider Appeal

CMH ID# (if applicable): _____ Consumer Name: _____

Primary Clinician: _____ Primary Provider: _____

Name of Filer: _____

Name of Filing Agency: _____

Agency's Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Related to:

Date of Receipt of Adverse Notice _____

☐ Claims Payment and/or Adjustment to Payment **(please attach a copy of the denied claim form)**

☐ Authorizations

KCMHSAS Claim #: _____

Program code denied: _____

Date range denied: _____

# of units denied: _____
(i.e., months, days, sessions, etc.)

☐ Other Non-Clinical Issue (please explain): _____

☐ Denial or Suspension of Provider Panel Status: _____

Desired resolution for this Appeal:

Standard or criteria based on KCMHSAS policy 02.02 (Provider Grievance and Appeals [non-clinical]), sections 1.D and 1.E upon which the Appeal is based and supporting information or documentation related to the criteria:

If Level II Appeal, provide new information to support a Level II Appeal:

Signature _____ Printed Name _____ Date _____

Provider Appeal

Note: if this appeal form contains insufficient information, it will automatically be denied.

FOR OFFICE USE ONLY

KCMHSAS Level I Determination

Decision: ☐ approved ☐ partial approval ☐ denied Date of approval/denial: _____

Signature: _____

Comments: cc: Population Director

FOR OFFICE USE ONLY

KCMHSAS Level II Determination

Decision: ☐ approved ☐ partial approval ☐ denied Date of approval/denial: _____

Signature: _____

Comments: cc: Population Director

Send all Appeal forms to:

Kalamazoo Community Mental Health Substance Abuse Services
Attn: Program Specialist, KCMHSAS Administration/Finance
2030 Portage Street
Kalamazoo MI 49001