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| **Regional Service Provider Claim Payment Appeal Form** | | | | | | | | |
| **Providers must use this form to appeal service claims denied by Lenawee, Livingston,**  **Monroe, Washtenaw or CMHPSM SUD payers.** | | | | | | | | |
| Provider Name: |  | | | Appeal Date: | |  | | |
| Contact Person: |  | | | Contact Email: | |  | | |
| Contact Phone: |  | | | Contact Fax: | |  | | |
| **CMHPSM Payer** | | | | | | | | |
| Lenawee | | Livingston | Monroe | | Washtenaw | | | CMHPSM SUD |
|  | | | | | | | | |
| **EHR Claim ID Number(s)** | | | | | | | | |
|  | | | | | | | | |
| **EHR Batch Number(s)** | | | | | | | | |
|  | | | | | | | | |
| **Denial Date and Reason for Denial**   |  | | --- | |  |   **Basis of Appeal** | | | | | | | | |
|  | | | | | | | | |
| **Resolution Requested** | | | | | | | | |
|  | | | | | | | | |
| **Service Provider Authorized Signature** | | | | | | | **Date** | |
|  | | | | | | |  | |
| Completed appeal form, including supporting documentation, should be faxed or e-mailed directly to the appropriate CMHPSM Payer department (i.e. Appeal of Lenawee CMH denial of payment sent to Lenawee CMH, appeal of CMHPSM-SUD sent to CMHPSM, etc.) | | | | | | | | |
| **Received by CMHPSM Payer** | | | | | | | **Date** | |
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| **Determination / Outcome** | **Date** |
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