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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**

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**Basis of Appeal**  |
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| **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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