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| **CMHPSM 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 MH | Washtenaw MH | | | CMHPSM - Monroe SUD | | CMHPSM – Wash. SUD |
|  | | | | | | | | | |
| **CRCT EHR Claim ID Number(s)** | | | | | | | | | |
|  | | | | | | | | | |
| **CRCT 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 entity (i.e. Appeal of a Lenawee CMH denial of payment sent to Lenawee CMH, appeal of Washtenaw SUD claim sent to CMHPSM, etc.) Please refer to the [CMHPSM Claims Payment & Appeal policy](https://www.cmhpsm.org/regional-policies) for more information. | | | | | | | | | |
| **Received by CMHPSM Partner Payer** | | | | | | | | **Date** | |
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| **Determination / Outcome** | **Date** |
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