PROVIDER RECONSIDERATION FORM

DIRECTIONS: Please complete this form when requesting a reconsideration of an adverse decision made by the Genesee Health System Utilization Management Department and attach any relevant clinical documentation. Please fax to (810) 257-1347.

Consumer Name: _____

Case Number: _____

Medicaid ID#: _____

Admission Date: _____ Discharge Date: _____

Provider Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Attending Physician (if applicable): _____

Provider Type:

[ ] Hospital
[ ] Partial Hospital
[ ] Crisis Residential
[ ] Crisis Stabilization
[ ] Residential
[ ] CLS
[ ] Case Management
[[ ] Other: _____

Date of Adverse Determination or Pending by GHS UM: _____

RATIONALE FOR REQUESTING A RECONSIDERATION: (Briefly describe clinical rationale for requesting a reconsideration. Note if additional clinical documentation is attached.)

Signature: _____ Date: _____

Name (print): _____

GHS UM Use Only:

Indicate which UM decision applies:

____ Pended for psychiatric review due to medical necessity dispute. Physician will approve or deny continued services.

____ Denial by UM Coordinator.

Last day approved by UM review staff: _____

GHS UTILIZATION MANAGEMENT DEPARTMENT REVIEW (UM Manager, Director, or Psychiatrist when necessary):

TYPE/SOURCE OF REVIEW OF INFORMATION:

[ ] Decision unchanged [ ] Decision changed

Disposition: _____

Signature: _____ Date: _____

Mail or fax this form to: GHS Utilization Management Department, 705 S. Dort HWY, Flint, MI 48503
Telephone Number (810) 257-1325 Fax Number (810) 257-1347.
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