**DSAMH PROMISE APPEAL FORM**

**Appeal Type:**  Referral (Complete I below) Level of care/Discharge of existing beneficiary (Complete II below)

1. **REFERRAL APPEAL**

Provider Name:

Beneficiary Name: MCI:

The following must have been completed prior to submitting an appeal:

Consulted Previous or Current Provider: Yes No

Obtained updated clinical documentation: Yes No

Met with/attempted to assess beneficiary: Yes No (Please attach relevant documentation)

Consulted PAC and EEU: Yes No

If proceeding with appeal:

Reason for Appeal of Referral:

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Name of Person Submitting:

Signature of Person Submitting: Date:

1. **LEVEL OF CARE/DISCHARGE APPEAL**

Provider Name:

Beneficiary Name: MCI:

The following must have been completed prior to submitting an appeal:

Level of care/potential discharge discussed with PAC:  Yes  No

Provide documentation to support interventions attempted to address issues:

☐ Last month of progress notes

☐ Last three (3) psychiatric notes

☐ Most recent MAR

☐ Coordination of care efforts

Additional information may be requested, as needed.

If current level of care is appropriate, what barriers prevent this provider maintaining client or re-admitting client in the near future?

Other narrative that may support level of care/discharge determination:

Submitted by: Date:

This appeal request form, and supporting clinical and other documentation, should be submitted via secure transmission to [DHSS\_DSAMH\_EEU\_Appeals@delaware.gov](mailto:DHSS_DSAMH_EEU_Appeals@delaware.gov). If you have any questions regarding this process, or a specific appeal, please contact the EEU at 302-255-9460.

**FOR DSAMH USE ONLY**

Date Received:

Request Approved

Request Denied Reason request denied:

Chief of Clinical Services Signature: Date: