**DSAMH EEU Inpatient Appeal Request Form**

(Psychiatric Hospitals and Substance Use Disorder Residential Facilities)

Facility Making Request:

Patient Name:

Date of Admission:

DSAMH Last Covered Day:

Reason Coverage Discontinued:

Reason appeal is being requested:

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Facility Contact Person:

Signature:

Date:

This appeal request form, and supporting clinical and other documentation, should be submitted via secure transmission to 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:

**Provider Appeal of Initial Decision:**

Additional information provided:

Name of Person Submitting:

Signature of Person Submitting:

Date:

Decisions regarding the appeal will be made within 30 days of receipt of the appeal. All appeal decisions are final.

**FOR DSAMH USE ONLY**

Date Received:

[ ]  Request Approved

[ ]  Request Denied Reason request denied:

Chief of Clinical Services Signature: Date: