

APPEAL SUBMISSION CHECKLIST FOR MENTAL HEALTH PROVIDERS

Provider Name and provider contact information:	
Bene	ficiary initials/MRN: RU:
Chec	k all items attached:
	etter with narrative explaining the basis of your appeal
\underline{D}	ocuments providing evidence for the basis of your appeal (check all that apply):
	Copy of NOABD notice you are appealing
	Copy of Service Authorization Form (MHC036)
	nitial Clinical/Psychiatric Assessment (MHC033, MHC100, MHC113)
	Other CCMHP approved assessment (Initial/Annual)
	annual Update Assessment (MHC065)
\square N	Medical Necessity Criteria Form (MHC18)
☐ P	Partnership Plan for Wellness (MHC021, MHC110, MHC105)
	CALOCUS (MHA091) / LOCUS (MHA092)
	applicable Progress Notes
☐ P	roof of Medi-Cal Eligibility for time frame of appeal if applicable
\square N	Medication Treatment Consent Forms
	Recent Hospital Records
	Other