North Sound
Behavioral Health Organization, LLC
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Denial Review Request

In order for North Sound BHO to consider a denial review request *all* of the following information must be sent via *secure/encrypted* email to denials@northsoundbho.org

- ☐ **Denial Review Request Form (this form)**
- ☐ **Assessment/Intake Evaluation** *(include related documentation below if not contained in the body of the assessment document)*
  - ☐ **Information regarding current physical health status, including any medications the individual is taking**
  - ☐ **Current co-morbid mental health or substance use issues and treatment status, including GAIN-SS**
  - ☐ **Discharge Summary if individual discharged from your agency within the last 6 months**
- ☐ **Other documentation used to make the recommendation (i.e. police rpts, driving abstract, etc.)**

Assessor's Name _____ **Assessor's Phone** _____
Email for North Sound BHO to send response _____

Request for Service Date _____ **Assessment Date** _____
Type of Decision (check one):
☐ Standard *(must be submitted to North Sound BHO within 10 business days of request for service*)*
☐ Expedited *(must be submitted to North Sound BHO within 3 business days of request for service*)*
If submitting to North Sound BHO beyond the timeline above, it is considered an extension and you **must identify who is requesting the extension and why below*

Extension Request (*Identify who is requesting an extension if submitting this request to North Sound BHO beyond the timeline, standard or expedited, noted above, or mark N/A*):
☐ N/A ☐ Extension requested by provider ☐ Extension requested by individual/authorized representative

Reason for extension request _____

Funding
☐ Medicaid ☐ State Funding ProviderOne ID# _____

Name _____ **DOB** _____

Name of Parent/Guardian/Authorized Representative (if applicable) _____

Mailing Address _____ **City** _____ **Zip Code** _____
☐ Individual does not have a mailing address or does not want notice to be mailed and will pick up at the agency.
NOTE: Correspondence will be sent to the address provided. If the individual has specified an address for confidential communication, please be sure to give **only** that address.

Does the individual need notification in an alternative format? If yes, please identify preferred language or other alternative format.

☐ Other language (please specify) ☐ Large font
☐ Braille ☐ Audio recording

Individual does NOT qualify for services for the following reason (Select only **ONE):**

☐ The individual is determined **NOT** to have a ☐ mental health/ ☐ substance use/ ☐ behavioral health (select one; only select behavioral health if request is for co-occurring services) disorder per DSM-5.

☐ The individual's diagnosis is **NOT** a covered diagnosis per Access to Care Standards.

☐ The individual does not meet functional impairment criteria for mental health services (SMI or SED).

☐ The individual does not meet functional impairment criteria for substance use services (ASAM criteria).

☐ The individual's impairment(s) and corresponding need(s) is **NOT** the result of a covered behavioral health disorder.

☐ Behavioral health intervention is **NOT** deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning that is a result of the individual's covered behavioral health disorder.

☐ The individual is **NOT** expected to benefit from the intervention.

☐ The individual's unmet need is more appropriately met by other formal or informal system(s) or support(s). Identify system(s) that the individual is currently connected to and receiving services from. If selecting this reason, ***you must identify the system and explain how this system(s) provides for the unmet need of the individual*** (do NOT include systems that the individual has only been referred to and is not actually connected to yet).

System & Needs Addressed

Please provide any additional information you want the reviewer to consider.