A. Appeal Number	B. Appeal Reference Information: Reserved for DMH Use:

LACDMH - LMHP – Specialty Mental Health Services – Appeal Form

READ INSTRUCTIONS PRIOR TO COMPLETING AND SIGNING THIS FORM.

C. Provider Name:
Provider Address:

D. Provider Telephone:

Provider Fax Number:

E. Rendering Provider No:

F. Claim Type
Check Only One
Inpatient Setting [ ]
Outpatient [ ]

G. As provided by Section 1850.305 of Title 9, Chapter 11 of the Cal. Code of Regulations, I am submitting an appeal of my claim as defined below. I have enclosed all documentation required for this appeal.

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

H. Client's Name

I. Client's Medi-Cal I.D.

J. Reason for Appeal (Enclose all supporting documentation, including copy of claim)	K. Denial Code	L. # of Min.		M. Claim ID #	N. POS	O. Date of Service	P. Procedure Code	Q. Diagnosis Code
			01					
			02					
			03					
			04					
			05					
			06					
			07					
			08					
			09					
			10					
			11					
			12					
			13					

R. Common Appeal Reasons
CHECK ONLY ONE (IF APPLICABLE)

[ ] Eligibility	[ ] (POS Attached)
[ ] TAR/PA/HPA Denial	[ ] (TAR/PA/HPA Attached)
[ ] Crossover	[ ] (3rd Party Denial Attached)
[ ] Adjustments Request	[ ] (Paid Warrant Attached)
[ ] Past 6 Months SD/MC	[ ] (Billing History Attached)

This is to certify that the information contained above is true, accurate and complete and that the Provider has read, understands, and agrees to be bound by and comply with the conditions required by the County of Los Angeles DMH Local Mental Health Plan.

S. Signature of Provider

Date