

EPSDT REVIEW NOTIFICATION

714 Market Street/5th Floor/Philadelphia, PA 19106

215-413-3100 telephone/215-413-7184 fax

Date: _____

To (Agency): _____

Provider #: _____

From: CBH Child and Adolescent Service Management

FAX #: _____

Child/Adol.: _____

MA#: _____

Date Received: _____

Approved Auth. Period: _____ **Requested Auth. Period:** _____

Services Requested: TSS _____ CM _____

MT _____ TSS Aide _____

BSC _____ Other _____

MA97:
Evaluation: Date: _____

Treatment Plan:

Plan of Care:

Interagency Team Meeting:

Interagency Recommendations and Evaluation recommendations are consistent:

Service Coordination Plan (CM only):

School Coordination Plan (In school services only):

Additional Comments:

_____ **The services have been APPROVED as specified in "Services Requested" and "Authorization Period" stated above.** AUTHORIZATION IS CONTINGENT UPON CHILD'S/ADOLESCENT'S MEDICAL ASSISTANCE ELIGIBILITY.

AUTHORIZATION LETTERS WILL BE FORWARDED BY MAIL.

_____ Packet not reviewed prior to requested start date

_____ Client was not CBH eligible for entire period

_____ **The requested services have been PENDED for the following reasons:** REQUESTED MATERIAL MUST BE RE-SUBMITTED WITHIN 15 DAYS OF THE DATE OF THIS NOTIFICATION TO BE CONSIDERED VALID.

_____ **The requested services have been sent to OMHSAS for Impartial Review**

_____ **The information received cannot be reviewed due to insufficient documentation**