VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Agency of Human Services
[Phone] 802-879-5900
http://dvha.vermont.gov

Request for Reconsideration: For Mental Health and Applied Behavior Analysis Services

This request form must be completed **in its entirety** and submitted to the utilization reviewer no later than 14 days after the DVHA or DMH Utilization Reviewer first gives notice, either written or oral, to the provider, inpatient or residential facility that authorization for a particular member will end or authorization will be continued at a lower reimbursement rate or that ABA services will not be authorized or will be authorized at a lesser duration or amount than the original request.

Date of Request: _____

Dates Provider is Requesting be Reviewed (must list both begin and end date for review): *an end date must be provided as reviews cannot be open-ended
Begin: _____ **End:** _____

Reimbursement Rate Requested by Provider: _____
Name of Provider: _____
Name of Member: _____
Member Medicaid ID Number: _____

The Following Section Must Be Completed by Attending Physician or Licensed Treating Provider (for ABA or Residential Services)
1. For the days being reviewed, please describe the severity of symptoms that required the requested level of care:

2. For the days being reviewed, please describe the services provided to address the above described symptoms that required the requested level of care:

Name of Attending Physician or Licensed Provider Completing Form:_____