LEVEL ONE
MCCMH-SUBSTANCE USE SERVICES APPEAL FORM

Program Name: _____ **Date of Appeal:**_____

Date of Audit: _____ **Date of MCCMH SUD Receipt**:_____

Case Number: _____

Type of audit the appeal is in response to:

☐ ***Quality Assurance Audit: Sent to Quality Coordinator at MCCMH-SUD***
☐ ***Medicaid Verification Audit: Send to MVA Auditor***
☐ ***Other Financial Audit: Sent to Finance Administrator at MCCMH-SUD***

Reason for Appeal (must include supporting documentation):

Desired Outcome or Resolution:

_____ _____
Program Director/Clinical Supervisor Signature **Date**

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LEVEL TWO
MCCMH-SUBSTANCE USE SERVICES APPEAL FORM

Program Name: _____ **Date of Appeal**:_____

Date of Audit: _____ **Date of MCCMH SUD Receipt**:_____

Case Number:_____

Type of audit the appeal is in response to:

☐ ***Quality Assurance Audit: Sent to SUD Administrator at MCCMH-SUD***
☐ ***Medicaid Verification Audit: Send to Finance Administrator***
☐ ***Other Financial Audit: Sent to SUD Director at MCCMH-SUD***

Decision that was made by the MCCMH-SUD auditor on Level One Appeal:

Reason for Level Two Appeal (must include supporting documentation):

Desired Outcome or Resolution:

_____ _____
Program Director/Clinical Supervisor Signature **Date**

LEVEL THREE
MCCMH-SUBSTANCE USE SERVICES APPEAL FORM

Program Name: _____ **Date of Appeal**:_____

Date of Audit: _____ **Date of MCCMH SUD Receipt**:_____

Case Number:_____

Type of audit the appeal is in response to:

☐ ***Quality Assurance Audit: Sent to SUD Director at MCCMH-SUD***
☐ ***Medicaid Verification Audit: Send SUD Director Auditor***

Decision that was made by the MCCMH-SUD auditor for Level One Appeal:

Decision that was made by SUD Administrator for Level Two Appeal:

Reason for Level Three Appeal (must include supporting documentation):

Desired Outcome or Resolution:

_____ _____
Program Director/Clinical Supervisor Signature **Date**

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