North Sound
Behavioral Health Organization, LLC
301 Valley Mall Way, Suite 110, Mount Vernon, WA 98273
http://northsoundbho.org • 360.416.7013 • 800.684.3555 • F 360.416.7017

Denial Review Request for Intensive Service Programs*

**If requesting denial of authorization for all behavioral health services use the regular Denial Review Request form.*

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 (DRR) Form** *(this form)*
☐ **Referral Packet**

The DRR must be submitted to North Sound BHO within 10 business days of referral date. If outside this timeline, complete the Extension Request section.

BHA Staff Requesting Denial **Phone**
Email for North Sound BHO to send response

Referral Date **Referral Review Date**
Referral was for (check one):

☐ Wraparound with Intensive Services (WISe)
☐ Geriatric Transitions Program (GTP)
☐ Intensive Outpatient Program for Adults (IOP; mental health only)
☐ Integrated Dual Disorder Treatment (IDDT)
☐ Program of Assertive Community Treatment (PACT)
☐ Mental Health Services in a Residential Setting
☐ Substance Use Residential Services

Extension Request (*Identify who is requesting an extension if submitting this request to North Sound BHO beyond 10 days of the referral date or mark N/A*):
☐ N/A ☐ Extension requested by provider ☐ Extension requested by individual/authorized representative

Reason for extension request

Client 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)
☐ Braille

☐ Large font
☐ Audio recording

Individual does <u>NOT</u> qualify for the requested service for the following reason (Select only **<u>ONE</u>):**

☐ The concern(s) for which the intervention is being requested is not a covered diagnosis or related to a covered diagnosis.

☐ The individual does not meet admission criteria for the requested intervention.

☐ The requested behavioral health intervention is **<u>NOT</u>** 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 **<u>NOT</u>** expected to benefit from the intervention as the intervention is not considered best practice for the individual's impairment(s) and corresponding need(s).

☐ The individual is **<u>NOT</u>** expected to benefit from the intervention as the intervention has already been tried and shown not to be the best fit for the individual.

☐ The individual's unmet need is more appropriately met by other formal or informal system(s) or support(s). Identify service(s)/system(s) that the individual is currently connected to and receiving services from or service(s) individual is eligible for within the North Sound BHO network. If selecting this reason, ***you must identify the system and explain how this system(s) provides for the unmet need of the individual.***

Service/System & Needs Addressed

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