DSAMH EEU Inpatient Appeal Request Form
(Psychiatric Hospitals and Substance Use Disorder Residential Facilities)

Facility Making Request: _____

Patient Name: _____

Date of Admission: _____

DSAMH Last Covered Day: _____

Reason Coverage Discontinued:

_____

Reason appeal is being requested:

_____

_____

_____

_____

Facility Contact Person: _____

Signature: _____

Date: _____

This appeal request form, and supporting clinical and other documentation, should be submitted via secure transmission to DHSS_DSAMH_EEU_Appeals@delaware.gov. If you have any questions regarding this process, or aspecific appeal, please contact the EEU at 302-255-9460.

FOR DSAMH USE ONLY

Date Received:_____

☐ Request Approved
☐ Request Denied Reason request denied:_____

Chief of Clinical Services Signature:_____Date:_____

Provider Appeal of Initial Decision:

Additional information provided: _____

Name of Person Submitting: _____

Signature of Person Submitting: _____

Date: _____

Decisions regarding the appeal will be made within 30 days of receipt of the appeal. All appeal decisions are final.

FOR DSAMH USE ONLY

Date Received:_____

☐ Request Approved

☐ Request Denied Reason request denied:_____

Chief of Clinical Services Signature:_____ Date:_____