USHS APPEAL REQUEST

| Client Name: | CSP# | Date: |
|--|---------------------------------|---------------------|
| Date of Denial: | | |
| Reason for Denial: | | |
| Request for denial reversal: (Providence of the Control of the Con | de statements and documentation | supporting request) |
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| Provider Agency Staff Member | | Date: |
| | | Date: |
| Trovider Agency Stair Member | | Datc |
| | | |
| CSB USE ONLY: | | |
| □Approved | Date of Decision: | |
| □Denied | | |
| Explanation of decision: | | |
| | | |
| | | |
| | | |
| CSB Staff Member: | | Date: |
| CSB Staff Member: | | Date: |