Comagine Health

Oregon Behavioral Health Support Program

Request for 1915i Reconsideration

Contact information is required in the event the OBHSP team needs to outreach

A detailed summary of the reconsideration request is required. Please reference information in attached documentation to support the reconsideration request

Comagine Health

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Oregon Behavioral Health Support Program

IQA 1915(i) Assessment Reconsideration Request

Please send completed requests to Comagine Health via one of the following methods:

Fax: 877-575-8309

Secure email: ORBHsupport@comagine.org

Mail: Comagine Health – OBHSP
650 NE Holladay St., Suite 1700
Portland, OR 97232

Reconsideration Request Date:

Consumer Name: Medicaid ID#:

Provider Name: Provider#:

Address: Phone:

Point of Contact for Reconsideration Request:

Name/Title: Phone:

Email:

1915(i) authorization period related to the reconsideration request. Date From: To:

1. What part of the 1915(i) assessment is this reconsideration request related to?

☐ Level of Service Inventory Instrument (LSi)

Any request for review of an LSi score must be facilitated by providers within 10 business days of initial reporting of the scores (to the provider) by the IQA.

☐ Level of Care Utilization System (LOCUS)

☐ Person-Centered Service Plan (PCSP)

☐ Other:

Please provide a comprehensive summary of the reconsideration request. Details to include page numbers of documentation to support the reconsideration and/or assessment document line items.

Check one or more of the boxes below. Please make note of the applicable timelines.

Check all boxes and include dates where applicable for supporting documentation

Reconsideration Documentation. Supporting documentation is required to be submitted with each reconsideration request.

List all documents that are being submitting with the appeal (check all that apply):

- ☐ Clinical/Progress Notes Date From: To:
- ☐ Mental Health Assessment Date:
- ☐ Psychiatric/Psychological Evaluation Date:
- ☐ Incident Reports (can include police reports)
- ☐ Behavioral Health Treatment Plan/Behavior Support Plan Date:
- ☐ Residential Care Plan Date:
- ☐ Consumer History and Physical Date:
- ☐ Medication Logs (MARs)
- ☐ ADL/IADL Logs
- ☐ Medical Assessment/Evaluation(s) (physical/speech therapy, acute, etc.) Date/s:
- ☐ Other (provide details):

Signature

I hereby confirm that all information provided is accurate and current as of the date of the reconsideration request.

Signature | Name and Title | Date

Save As | Print | Clear Form

The form must be signed and dated for the reconsideration request to be processed

Comagine Health

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Once the form is complete, please submit by email, fax, or mail.

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Mail: 650 NE Holladay St. Suite 1700, Portland, OR 97232