DEDUCTIBLE ADJUSTMENT REQUEST

To: Program/Region Mgr_____ Mail Stop (MS#)_____ Date_____
From:_____ Title_____ (MS#) _____

RE: Client Name_____ CCBH SYSTEM Case# _____

UMDAP Annual Deductible $_____ Monthly Rate $_____ Contract Yr_____

CRITERIA: (Check those applicable for Deductible Adjustment)

Stated inability to pay due to _____
Will not return for recommended treatment and without treatment the client's mental health will diminish without treatment, patient may become suicidal and/or injure self or others.
Recommended by Therapist that reduction be granted. Therapist_____
Signature

Amount Patient will pay: Annual $_____ Monthly $ _____
STATEMENT:(Further justification)

_____
_____
_____
_____
_____
_____
_____

Continue on attached sheet if necessary

Human Service Specialist Recommendation (If Needed)**:** ☐ **APPROVAL** ☐ **DISAPPROVAL** ☐ **NO RECOMMENDATION**

_____

_____

HSS Signature_____

Adjustment Review: ☐ Disapproved

☐ Approved For

Annual Deductible $ _____
Payable Monthly at $ _____

_____
Program/Region Mgr. Signature

☐ Request Unjustified – Denied ☐ Request Justified Reduce To Recommended Amount

Final and/or Appeal Review:
ADMINSTRATOR_____ **ANNUAL**_____

MONTHLY AT $_____

Fax To: BHS Billing Unit (858) 467-9682
Route cc: Human Service Specialist Review
HHSA: MHS-661 (06/2015)