Request for Reconsideration of Qualified Evaluator (QE) Recommendation

**Revised: October 16, 2019**

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| Date: | | **District/ SPOA Information:** | |
| Child Information | | | |
| NAME: | DOB: | | medicaid number: |

| Type of Request | |
| --- | --- |
| rECONSIDERATION OF rECOMmendation | **CLARIFICATION OF RECOMMENDATION** |

| Please Complete All Questions Below |
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|  |  |
| --- | --- |
| 1. Date of last suitability assessment: |  |
| 2. Name of QE: |  |
| 3. Current recommendation by QE: |  |
| 4. SPOA contact information: |  |
| **5.** What is the reason for this request  (please explain in detail): |  |
| **6.** If a reconsideration of the QE recommendation is being requested (please explain in detail) what attempts were made to stabilize the child/adolescent at the recommended level of care: |  |
| **7.** Additional comments for consideration: |  |

| *BELOW SECTION TO BE COMPLETED BY MAGELLAN MEDICAID ADMINISTRATION ONLY* | | | |
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| **APPROVED** | Denied | **COURT ORDERED** | **Initials** |
| Comments | | | |