NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

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Executive Deputy Commissioner

Clinical Review Criteria, Policies, and Procedures Submission Coversheet

Insurer Name: _____

Product Line: Choose an item.

Contracted UR Agent (if applicable; if insurer contracts with more than one UR agent, please indicate UR agents in space below. Indicate in table UR agent for each service):

_____

_____

_____

Date Submitted: _____

Name of Individual Submitting Documentation: _____

Title: _____

Contact Phone Number: _____

Contact Email Address: _____

1. Policies and Procedures related to Utilization Review (UR) staff

Indicate with an X in the column if a document is attached.

Attachment	Description	Attached
A.	Training for staff performing UR	
B.	Testing for and ensuring inter-rater reliability (IRR)	

2. Policies and Procedures

Indicate with an X in each column if a document is attached.

List additional categories of service under "Other" in rows V1-V4 below. Attach additional sheets if necessary.

Attachment	Service	**Covered Benefit - LOC Review Tool** *Document Attached*	**Covered Benefit - Policies & Procedures** *Document Attached*	**Covered Benefit - No UR** *Attestation Attached*	**Not a Covered Benefit** *Attestation Attached*
C.	Adult MH Inpatient				
D.	Adult MH Residential				
E.	Adult MH PHP				
F.	Adult MH IOP				
G.	Adult MH Clinic				
H.	Adult MH CDT				
I.	Adult MH ACT				

J.	Adult MH PROS				
K.	Adult BH HCBS				
L.	Adult Office-based Outpatient MH				
M.	Child/Adolescent MH Inpatient				
N.	Child/Adolescent MH Residential				
O.	Child/Adolescent MH PHP				
P.	Child/Adolescent MH IOP				
Q.	Child/Adolescent MH Clinic				
R.	Child/Adolescent MH ACT				
S.	Child/Adolescent MH CFTSS				
T.	Child/Adolescent HCBS/1915(c) Waiver				
U.	Child/Adolescent Office-based Outpatient MH				
V1.	Other:				
V2.	Other:				
V3.	Other:				
V4.	Other:				