# APPEAL REQUEST FORM

## BERRIEN MENTAL HEALTH AUTHORITY (d/b/a Riverwood Center)

Provider Name: _____ Today's Date: _____

**Please complete the form below with detailed information. Attach additional sheets and supporting documents if necessary to your Appeal Request.**

Reason for dispute:

_____
_____
_____
_____
_____
_____
_____

Additional information:

_____
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_____
_____

Provider Signature: _____

Printed Name: _____

Date Notified of Riverwood's network participation decision: _____

**For Office Use Only**

Date reconsideration received: _____

Date request reviewed by first- level panel: _____

Determination and findings: _____

Date request reviewed by second-level panel (as applicable): _____

Determination and findings: _____