Reconsideration of Qualified Evaluator (QE) Recommendation

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

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

| Please Fully 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/youth at the recommended level of care:** |  |
| **7. Additional comments for consideration:** |  |

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