CURRENT OR POTENTIAL CONTRACTING PROVIDER REQUEST

FOR MEDICAL NECESSITY CRITERIA UNDER MHPAEA ONLY

[Insert name of psychiatrist]

[Insert address of psychiatrist]

[Insert email or other contact information, if desired]

[Insert date]

[Insert name of appropriate contact at plan]

[Insert title]

[Insert mailing address]

Dear Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

The Mental Health Parity and Addiction Equity Act of 2008 and Final Rules (29 C.F.R. §2590.712(d)(1)) permit current and potential contracting providers to request a copy of the medical necessity criteria used by the plan to make determinations regarding mental health and substance use disorder benefits offered under the plan.

I am a current or potential contracting provider with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [health plan]. I am currently treating an individual with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[diagnosis or diagnoses] and I hereby request a copy of the medical necessity criteria used by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[health plan] to make determinations regarding mental health and substance use disorder benefits available under the plan for the treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [diagnosis or diagnoses]. In addition, please provide any information you have regarding the processes, strategies, evidentiary standards, and other factors used by the plan in applying the medical necessity criteria to mental health and substance use disorder benefits available under the plan.

Please forward this information to the following address as soon as possible, but in no event later than 30 days from the date of this request:

[Insert name]

[Insert mailing address]

If the addressee listed above is not the health plan or a plan administrator authorized to respond to the above request, please provide the correct name and contact information for same.

Thank you very much for your assistance in this matter.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

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