

Provider Agency:	MEMBER Name:	
Service Type:	Record #:	MID:
Reviewer Name and Credentials:		
Date Range Reviewed:	Date of Review:	
A. CONSIDERATIONS:		
	YES	NO
A1. Was an assessment pathway followed to form diagnosis?		
A2. Have differential diagnoses been ruled out?		
A3. Does the Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA) support the diagnosis according to latest edition of DSM criteria?		
B. CLINICAL DETERMINATION:		Check one
B1. Documents reviewed support a pathway was used.		
B2. Documents reviewed do not support a pathway was used to make diagnostic determination		

Provider Name:		Review Date:
Record:	Mid:	Member Name:
DOCUMENTS REVIEWED		
<p>Check items reviewed: If applicable</p> <p><input type="checkbox"/> Comprehensive Clinical Assessment/Diagnostic Assessment Report, with signatures, or other assessments used to develop the plan</p> <p><input type="checkbox"/> If Applicable does the provider follow the established clinical pathways and/or adheres to HEDIS measure(s).</p> <p><input type="checkbox"/> Other:</p>		
COMMENTS:		

Attach documents used to render decisions