Local Dispute Resolution Request Form

SECTION 1: Dispute Resolution Request

☐ Oral Request Date: _____	☐ Written Request Date: _____
Local Dispute Resolution Request for ☐ Standard Resolution (5 days) or ☐ Expedited Resolution (3 days)	
Who is requesting Local Dispute Resolution: ☐ Consumer's ☐ Authorized Representative	

SECTION 2: Personal Information

Consumer's Name		Home phone#	Work or Cell phone#	
Address (No. & Street, Apt#, etc.)		City	State	ZIP Code
Date of Birth	MH-WIN ID#:	Signature	Date Signed	
Provider Name:	Contact Person:	Provider phone#:	Date of Notice (if known)	

SECTION 3 - Have you chosen someone to assist or represent you with this request?

☐ YES (please fill-in information below)		**☐ NO**	
Name of Authorized Representative:		Home phone#	Work or Cell phone#
Address (No. & Street, Apt#, etc.)		City	State / ZIP Code
Representative Signature			Date Signed

SECTION 4 - Reason for Local Dispute Resolution Request

The following are my reason(s) for requesting a local Dispute Resolution. Use Additional Sheets if Needed

I would like an opportunity to look at case/medical file or any records that will be considered during the Dispute Resolution?

☐ Yes ☐ No

I would like an opportunity to present information for review/consideration during the Dispute Resolution process?

☐ Yes ☐ No

Form completed by: _____ Date completed: _____

LOCAL DISPUTE RESOLUTION REQUEST FORM NON-MEDICAID
INSTRUCTIONS FOR COMPLETION

SECTION 1 - Local Dispute Review Request
Check off if the request is filled out by consumer or authorized representative or if the form is being completed due to an oral request.

SECTION 2 - Personal Information
Enter information about the consumer who is the requesting the Local Dispute Resolution, including the provider information.

SECTION 3 - Have you chosen someone to assist or represent you with this request?
Enter information that identifies the authorized representative - the consumer may chose someone to represent them or assist with the appeal process.

SECTION 4 - Reason for Local Dispute Resolution Request

This form may be completed by the consumer/legal guardian, authorized representative, or any person including Agency, MCPN staff person who is assisting the consumer with the Local Dispute Resolution process.

Send form to:

Detroit Wayne Mental Health Authority Access Center
4707 St. Antoine , #506
Detroit, MI 48201
Fax: 1 (877) 909-3950