The Haymount Institute for Psychological Services

APPOINTMENT APPEAL FORM

Date: _____ **Patient Date of Birth**: _____

Patient Full Name: _____

Legal Guardian *(if applicable):* _____

Address: _____ **State**:_____ **Zip Code**: _____

Phone Number: _____

Date(s) of missed appointment(s): _____

Reason for missed appointment(s):

_____
_____
_____
_____
_____
_____

Attach any documentation supporting your request.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Please allow 7- 14 business days for a written response. Thank you.

For Office Use Only:
PTID: _____ CPTCODE: _____ CLINICIAN: _____

REVIEWED ON DATE: _____ REVIEWER: _____

APPROVED_____ DENIED _____ MAILED OUT: _____