ACBH SUD Med Necessity CQRT Tool Comment Sheet

Client Name:	Review Period: to
Client PSP#:	EOD: LOC:
Assessment Date(s):	Plan Date(s):

RC Item #	Comments (Include item number and <u>clear</u> description. Each **No** must have a comment.)

CQRT Reviewer Name:	Date:
CQRT Reviewer Signature/Credentials:	

v.11.1.2019

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