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 clear description. Each **No** must have a comment.)

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

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