ACBH SUD Med Necessity CQRT Tool Comment Sheet

Client Name:		Review Period: to		
Client PSP#:		EOD:	LOC:	
Assessment Date(s):		Plan Date(s):	Plan Date(s):	
RC		omments		
Item #	(Include item number and <u>clear</u>	nd <u>clear</u> description. Each No must have a comment.)		
CQRT Reviewer Name:		Date:		
CORT Reviewer Signature/Credentials:				

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RC					
Item #	Comments (Include item number and clear description, Each Ne must have a comment.)				
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CQRT Reviewer Name:		Date:			
		·			
CQRT Reviewer Signature/Credentials:					