



Client Name: [redacted]  
Medicaid ID: [redacted]  
DOB: [redacted]

The client meets Colorado Health Networks criteria for enhanced care management because:

- Client has diagnosis of Attention Deficit Hyperactivity Disorder
- Client has had greater than ten (10) psychotherapy sessions
- Client has no evidence of medication evaluation or management in your encounter data

Please review provider records and respond following items. Please check all that are true:

- Attention Deficit Hyperactivity is still an active diagnosis
- There is documentation of a medication evaluation or management services
  - By CMHC Provider
  - By primary care physician/pediatrician/ or other non-CMHC provider
- There is a medication evaluation scheduled
  - With CMHC provider
  - With non-CMHC provider
- Medication evaluation refused
  - By client
  - By parent/guardian

Other explanatory information:

Reviewer's Name: [redacted]  
Date: [redacted]  
Reviewer's Signature:

**Please Return this form to: CHN; Attn: Sheila Bowlin  
7150 Campus Dr, Ste. 300, Colorado Springs, CO 80920  
Or Via Fax: (719) 538 -1430**