Department of Corrections
WASHINGTON STATE

PATIENT APPEAL OF CARE REVIEW COMMITTEE DECISION

I have been informed on this date of the (check one):

☐ Dental ☐ Gender Dysphoria ☐ Hepatitis C ☐ Medical ☐ Mental Health ☐ Psychiatric

Care Review Committee (CRC) decision to **NOT** authorize the requested intervention and that I have the right to appeal the CRC decision that the requested intervention is **NOT** medically necessary per the Washington DOC Health Plan.

I wish to appeal the CRC decision and understand this appeal must be submitted within 5 days from the date of receiving DOC 13-182 Patient Notification of Care Review Committee Decision.

NAME	SIGNATURE	DATE

DOC NUMBER	FACILITY

APPEAL

Keep the yellow copy for your records and deliver the original to a **Health Services Manager (HSM)** at your facility or mail it to:

HQ CRC Appeals Committee
Department of Corrections
PO Box 41123
Olympia WA 98504-1123

DISTRIBUTION: WHITE – HEALTH RECORD CANARY – PATIENT