NEW YORK STATE DEPARTMENT OF HEALTH Disability Review Unit

Disability Review Team Certificate

Case Name			Case Number
Agency Name		Client ID Number (CIN)	Disability ID Number (DIN)
Diagnosis			
Review Date		Effective Date	Expiration Date
Disability Review Unit's Determination	ı (Written explanation mus	t be completed below.)	
□ Approved□ Disapproved	Group I Group I	I Medical Improvement Group	
Reasons for Determination			
Reasons for Determination			
Signature of Reviewing Physician		Signature of Case Reviewer	
DOH-5144 (6/15)			