REQUEST FOR APPEAL

Consumers who wish to have a review of a decision that affects their care may file an appeal by filling out this form. Decisions that may be appealed are those that deny, reduce, suspend, or terminate services that you have been getting. You may request an expedited appeal, if you believe that waiting 30 days for a decision on a standard appeal would cause problems with your health, including problems with your ability to gain, maintain, or regain important life functions.

You will not be subject to any manner of discrimination, penalty, sanction or restriction for exercising your appeal rights. You may request an appeal verbally, but you must also submit the request in writing. You may use this form. Remember to sign and date your request.

1. The following information is required to proceed with an appeal:

Today's Date:	
Name:	Birthday:
Legal Guardian (if on behalf of a minor):	
Address:	
City:	
Phone:	Best time to call:

2. Choose the decision(s) that you wish to appeal. You should have been informed on a Notice of Adverse Beneficiary Determination (NOABD) form of the decision affecting your care. (Attach additional sheets if necessary.)

- ☐ Your behavioral health diagnosis as identified by the assessment is not covered by the behavioral health plan.
- ☐ Your behavioral health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty behavioral health services from the behavioral health plan.
- ☐ The specialty behavioral services available from the behavioral health plan are not likely to help you maintain or improve your behavioral health condition.
- ☐ Your behavioral health condition would be responsive to treatment by a physical health care provider.

OR

- ☐ The behavioral health plan denied in whole or in part payment for services.
- ☐ The behavioral health plan failed to provide services in a timely manner.
- ☐ The behavioral health plan failed to act within the time frames for the disposition of grievance or to the resolution of expedited appeal.

3. Please add anything else you would like us to know. You may attach additional pages.

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SIGNATURE OF PERSON MAKING REQUEST Date:

RETURN THIS FORM TO:

Behavioral Health Plan Deputy Director
1270 Natividad Road
Salinas, CA 93906 (831) 796-1700

Date Received: _____ Received by: _____

Rev. 11/15/17