Clients may file a Standard Appeal either orally or in writing. **A Standard Oral Appeal must be followed up with a written, signed Appeal**. Standard appeals have a 30 day resolution time. This form may be used for the purpose of submitting the written Appeal. Clients may request an **Expedited Appeal** if the Standard Appeal process could jeopardize their life, health, or ability to regain maximum function. Expedited appeals will be resolved within 72 hours. **Please check "Expedited Appeal" box on reverse side if this applies.**

Clients may authorize a representative to act on their behalf at any time and will have opportunity to present evidence and testimony and make legal and factual arguments, in person or in writing during the 72 hour resolution process for expedited appeals or 30 day resolution period for a standard appeal. A 14 day extension may be requested by the client or the MHP for either type of appeal. Requests for an extension by the MHP will be for reasons in the interest of the client only.

Clients may request a **State Fair Hearing** after the Appeal process has been completed by contacting the **Patients' Rights Advocate** at **(559) 673-3508** or **(888) 275-9779** or the **State Ombudsman** at **(800) 896-4042** or TTY **(800) 896-2512** or email MHOmbudsman@dhcs.ca.gov. If the MHP does not resolve the appeal within the allotted time frames stated, the beneficiary will be deemed to have exhausted the appeal process and may initiate a State fair hearing.

The Quality Management Coordinator may be reached at **(559) 673-3508**, **(888) 275-9779** or TTY **(800) 735-2929**
Please return this completed form to the receptionist or mail in the self-addressed envelope to:

Madera County Mental Health Plan
P.O. Box 1288, Madera, CA 93639
TTY **(800) 735-2929**
Cal Relay Dial **711**
Speech to Speech **(866) 288-1909**

Madera County
Behavioral Health Services

APPEAL FORM

Beneficiaries may appeal an "**Adverse Benefit Determination**" by the Madera County Mental Health Plan (MHP).

An "**Adverse Benefit Determination**" is when the MHP:

1. Denies or limits authorization of a requested service, including the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. Reduces, suspends, or terminates a previously authorized service;
3. Denies, in whole or in part, payment for a service;
4. Fails to provide services in a timely manner;
5. Fails to act within the required timeframes for standard resolution of grievance and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

An **Appeal** must be filed with the Managed Care Coordinator within sixty (60) calendar days of the date of the Adverse Benefit Determination. Acknowledgement of receipt will be provided within 5 calendar days of the receipt of the appeal.

Please ask receptionist about your **right** to **free language assistance** services as well as alternative formats of this brochure. If you have **physical limitations**, we will help you find available, appropriate and accessible services.

MADERA COUNTY BEHAVIORAL HEALTH SERVICES
APPEAL FORM APLLICATION

Date: _____ ☐ EXPEDITED APPEAL

Beneficiary Name: _____ Birthdate: _____

Name of Legal Guardian (if on Behalf of a Minor): _____

_____ _____ _____

Address City / Zip Phone Number

Please describe the reason for requesting an Appeal (Please include *action* you received, if possible):

_____

_____

_____

_____

_____

_____

If you are requesting an Expedited review of this Appeal, please explain reasons: _____

_____

_____

What would you like to see happen to resolve this Appeal? _____

_____

_____

_____

I understand that the Managed Care staff will be authorized to contact any involved provider or other involved individual in order to resolve my Appeal. Managed Care will also be authorized to discuss any and all information that shall be needed to evaluate and resolve this Appeal.

_____

Signature / Date

~~FOR COUNTY USE ONLY~~

Resolution of Appeal: _____

_____

_____

Signature / Date