Clients may file a Standard Appeal either orally or in writing. **A Standard Oral Appeal must be followed up with a written, signed Appeal**. 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.

Clients may authorize a representative to act on their behalf any time.

Clients may request a **State Fair Hearing** after the Appeal process has been completed by contacting the **Patients' Rights Advocate** at (559) 673-3508, ext. 1267 or (888) 275-9779 or the **State Ombudsman** at (800) 896-4042 or TTY (800) 896-2512 or email MHOmbudsman@dhcs.ca.gov.

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
Behavioral Health Services
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 "**Action**" by the Madera County Mental Health Plan (MHP).

An "**Action**" is when the MHP:

1. Denies or modifies MHP payment authorization of a requested service, including the type or level of service;
2. Reduces, suspends, or terminates a previously authorized service;
3. Denies, in whole or in part, payment for a service;
4. Fails to act within the timeframes for disposition of standard grievances, the resolution of Standard Appeals, or the resolution of Expedited Appeals or,
5. Fails to provide services in a timely manner, as determined by the MHP.

An **Appeal** must be filed with the Managed Care Coordinator within 90 days of the date of the Action.

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

Beneficiary Name: _____

Date: _____ Birth Date: _____

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