Madera County
Behavioral Health Services

APPEAL FORM

Beneficiaries may appeal an "**Adverse Benefit Determination (ABD)**" 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) days of the date of the Adverse Benefit Determination.

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.

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.

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. 1311 or (888) 275-9779 or the **State Ombudsman** at (800) 896-4042 or TTY (800) 896-2512 or 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

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 *ABD* you received, if possible):

_____

_____

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_____

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

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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

Date

~~FOR COUNTY USE ONLY~~

Resolution of Appeal:

Signature / Date