Health Care Agency, Behavioral Health Services
Authority and Quality Improvement Services

Confidential Patient Information
W&I 5328 CFR 42 Part 2

GRIEVANCE OR APPEAL FORM

Use this form if you:

1) Wish to express dissatisfaction with any aspect of your treatment from Behavioral Health Services. This is called a **grievance**.

2) Wish to appeal a decision denying, reducing services and/or limiting your pre-authorized services. This is called an **appeal**.

You may use the pre-addressed envelopes next to this form to submit your appeal/grievance. To express your dissatisfaction without completing and submitting a form, you may speak to the provider representative at your clinic, the Service Chief at your clinic, or you may call Authority and Quality Improvement Services at (866) 308-3074 or (866) 308-3073 TDD.

Client information:

Client's Name: ______________________________ DOB: ______________

Street Address______________________________

City, State, Zip: ______________________________

Phone: (______) ________ – ____________ Social Security#: _________ –_______–____________

Clinic information:

Name of clinic/program where client is receiving services? ______________________________

Street address of clinic:______________________ City, State, Zip of clinic:______________________

If you are completing this form to file a grievance, please briefly describe your concern or dissatisfaction.

____

____

____

If you are completing this form to file an appeal, please answer the following:

Have you received a Notice of Action (NOA)? ____ NO ____YES _______________DATE

You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health including problems with your ability to gain, maintain or regain important life functions. Would you like to request an expedited appeal? _____ NO ______ YES

Please Specify reason:

____

____

____

If you are completing this form, but you are not the client receiving services, what is your relationship to the client?

Relationship______________________ Your name ______________________

Your phone number______________________

______________________________ ______________________________

Signature of client or authorized representative Date

F346-706E 06/16 DTP318