REQUEST FOR APPEAL

Persons In Care who wish to have a review of a decision that affects their care may file an appeal by filling out this form. 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. Remember to sign and date your request.

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

Today's Date:	
Name:	Date of Birth:
Legal Guardian/Authorized Representative Name (If Applicable):	
Address:	City:
Phone:	Best time to call:

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

- ☐ You do not meet the criteria to access specialty mental health services (Denial or limited authorization of services)
- ☐ Your behavioral health condition would be responsive to treatment at a lower level of care. (Denial or limited authorization of services)
- ☐ The Behavioral Health Plan will no longer approve your treatment. (Reduction, suspension, or termination of a previously authorized service)
- ☐ The Plan denied in whole or in part payment for services. (Payment denial)
- ☐ The Plan has denied your dispute of financial liability regarding (denial of a beneficiary's request to dispute financial liability)
- ☐ The Plan failed to provide services in a timely manner. (Service timeliness)
- ☐ The Plan failed to act within the time frames for the disposition of grievance or to the resolution of expedited appeal. (Untimely response to appeal or grievance)
- ☐ Other Reason: ____

3. Additional pages may be attached to include any other information you would like us to know.

Person In Care's Signature: ____________________________ **Date**: ________________

RETURN THIS FORM TO:
Monterey County Behavioral Health Quality Department
1611 Bunker Hill Way, Suite 120
Salinas, Ca 93906
(831) 755-4545

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