Health Care Agency, Mental Health & Recovery Services
Quality Management Services

Confidential Patient Information
W&I 5328 42 CFR Part 2

GRIEVANCE OR APPEAL FORM

Use this form if you:

1) Wish to express dissatisfaction with any aspect of your treatment from Mental Health & Recovery Services. This is called a **grievance**. 2) Wish to appeal a decision denying, delaying, 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, the Service Chief or Program Director at this location, or you may call Quality Management Services at (866) 308-3074 or (866) 308-3073 TDD.

Client information:

Client's Name: ______________________________ DOB: ______________

Street Address ______________________________

City, State, Zip: ______________________________

Phone: ______________________________ Social Security#: ______________

Program information:

Name of program where client is receiving services?

Street address of program ______________ City, State, Zip of program ______________

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

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

Have you received a Notice of Adverse Benefit Determination (NOABD)?___ NO ____YES DATE ______________

You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your behavioral 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:

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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

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