Health Care Agency, Behavioral Health Service, AQIS CYBH Support

QRTips

November 2016

1) Grievance or Appeal Form

Please use the most current **Grievance and Appeal Form updated June 2016**. The revised version contains information on "Expedited Appeals" which must be presented to the client. Forms can be located on the following links:

http://ochealthinfo.com/bhs/about/medi_cal

http://ochealthinfo.com/bhs/about/cys/support/downloads

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.

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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:

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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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2) BHS EOC Summary Report

In the past, the **Coordination of Care Report** was utilized to determine if a client was open in other billing locations in the Mental Health Plan.

The **BHS EOC Summary Report** should now be accessed for coordination of care purposes. It is listed in Reports under the Caseload and Open EOC Reports. **Please run this report on all new clients to avoid duplication of services.**