Health Care Agency, Behavioral Health 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 Orange County Behavioral Health 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.

_____

_____

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:

_____

_____

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