



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, 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 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#: _____ - _____ - _____

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 (NABD)? 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