If you need assistance with completing this form:

- You may ask any Mental Health Plan staff to assist you.
- You may call Member Services.
  (916) 875-6069
  Toll Free 1-888-881-4 881
  TTY (916) 876-8853
- You may call the Patient Rights Advocate.
  (916) 333-3800

Sacramento County Board of Supervisors
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County Executive
Navdeep S. Gill

Department of Health and Human Services
Peter Beilenson, MD, MPH, Director

Division of Behavioral Health
Ryan Quist, Ph.D., Behavioral Health Services Director

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Published by:
The County of Sacramento
Division of Behavioral Health
8/1/2017
Note: Filing an Appeal following an Adverse Benefit Determination shall not adversely affect your services with Sacramento County Medical Health Plan. Member Services will respond with a resolution within thirty (30) calendar days for the Standard Appeal, or 72 hours for the Expedited Appeal. If the Expedited Appeal is denied, a written notice will be sent to the member and the Standard Appeal process will begin. Please check the appropriate box:

☐ Standard Appeal   ☐ Expedited Appeal

Please print or write legibly.

Date: __________________________  Service Location: __________________________

Client Name: ___________________  Date of Birth: __________________________

If client is a minor, enter the name of legal guardian filing on behalf of minor: __________________________

Address (City/State/Zip): __________________________

Phone Number (please indicate best time to call): __________________________

1. What is your Appeal? Please describe this issue in specific detail. Attach additional pages, if necessary.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. If you have checked the Expedited box, what is the reason you believe this Appeal needs to be expedited? Please include as much detailed information as possible. Attach additional pages if necessary.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. Have you discussed this issue with your service provider (service coordinator, therapist, counselor, psychiatrist, etc.)?  ☐ Yes  ☐ No

4. What would you like to see happen to resolve this Appeal?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of person making the Appeal: ________________________  Today’s date: ____________