If you need assistance with completing this form:

You may ask any Substance Use Prevention and Treatment Services 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

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Sacramento County Substance Use Prevention and Treatment Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Sacramento County Substance Use Prevention and Treatment Services
Quality Management – Member Services
7001-A East Parkway, Suite 300M
Sacramento, CA 95823

Sacramento County Substance Use Prevention and Treatment Services
Quality Management, Member Services
7001A East Parkway, Suite 300M
Sacramento, CA 95823

Stamp Required

Sacramento County Substance Use Prevention and Treatment Services

Appeal Form

Standard / Expedited

Appeal Form

Note: Filing an Appeal following an Adverse Benefit Determination shall not adversely affect your services with Sacramento County Substance Use Prevention and Treatment Services. 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.

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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.

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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?**

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____

Signature of person making the Appeal: ____________________ Today's date: __________