To obtain information on the status of a pending appeal or grievance, contact the Quality Improvement Coordinator at (800) 660-3570.

State Fair Hearings

Medi-Cal consumers may have any of their concerns addressed at any State Fair Hearing after completion of the Appeals/Grievance process. If you file for a hearing within ten (10) calendar days of a Notice of Adverse Benefit Determination that your behavioral health services are being denied, reduced or terminated, there are circumstances where the services can be continued until the hearing. A Request for a State Fair Hearing Form is included with each Notice of Adverse Benefit Determination to deny, reduce or terminate services. You may also request a State Fair Hearing by calling the State Department of Social Services at (800) 952-5253.

www.rcdmh.org

Quality Improvement Program
P.O. Box 7549
Riverside, CA 92513

RIVERSIDE COUNTY MENTAL HEALTH PLAN

APPEAL & GRIEVANCE PROCEDURE/REQUEST FORM

Steve Steinberg, Director

Riverside University HEALTH SYSTEM Behavioral Health

Revised September, 2017

QA 114 (Rev 9/17)

RIVERSIDE UNIVERSITY HEALTH SYSTEM — BEHAVIORAL HEALTH
APPEAL & GRIEVANCE PROCEDURE

A consumer and/or consumer's representative may file an appeal or grievance, orally or in writing, with his/her service provider, the C.A.R.E.S. Team, or the Quality Improvement Program.

An **Appeal** is a request for a review of an action by the authorization unit C.A.R.E.S. Team or the RUHS-BH Program. An action is defined as the modification or denial of a requested service from a consumer and/or a reduction, suspension, or termination of a previously authorized service.

A **Grievance** is defined as an expression of dissatisfaction concerning services received from the Mental Health Plan. Examples of grievances might be as follows: the quality of care or services provided, aspects of interpersonal relationships - such as rudeness of an employee, etc.

An **Expedited Appeal** may be requested when waiting up to 30 days for a standard Appeal decision will jeopardize your life, health or ability to maintain or regain maximum function. Expedited Appeals may be filed verbally. If the Mental Health Plan agrees that your Expedited Appeal meets the requirements, the Mental Health Plan will resolve your Expedited Appeal within 72 hours. If your Appeal does not meet the requirements for an Expedited Appeal, you will be notified right away orally and in writing within 2 calendar days. A denied Expedited Appeal may be filed as a standard Appeal.

Enclosed, is an Appeal/Grievance Request Form for the consumer and/or consumer's representative to use to file a written Appeal or Grievance. If you need assistance in completing the form, you can request help from your provider, or by calling the Quality Improvement Program at (800) 660-3570, or Patients' Rights at (800) 350-0519, or locally (951) 358-4600.

The Appeal/Grievance Request Form can be submitted to your provider, the program supervisor, the C.A.R.E.S. Team, or mailed directly to Quality Improvement in the self-addressed envelope available in your provider's lobby or reception area.

You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance.

For Appeals Only: Please indicate if the consumer is in any Medi-Cal funded residential treatment program.

Medi-Cal beneficiaries may file for a State Fair Hearing after the completion of the Appeal or Grievance process.

Riverside County Mental Health Plan
Quality Improvement Coordinator
P.O. Box 7549
Riverside, CA 92513
1-800-660-3570

For Office Use Only:
By: _____ Forward to: _____
Date: _____
Date Consumer Notified: _____
Outcome: _____

APPEAL/GRIEVANCE REQUEST

This form is used to file an Appeal or Grievance. If you need assistance in completing this form, you can request help from your provider, or by calling the Quality Improvement Program at (800) 660-3570 or Patients' Rights at (800) 350-0519, or locally, (951) 358-4600. A signed Release of Information Form needs to be submitted with this appeal/grievance form. The appeal/grievance form can be submitted to your clinician, the Program Supervisor, or mailed directly to the Quality Improvement Program at the address shown above.

I wish to file: ☐ **Appeal** ☐ **Grievance** ☐ **Expedited Appeal**

PLEASE PRINT
Your address and phone number are important. We need this information to contact you about the outcome of your Appeal or Grievance.

Your Name: _____

Your Address: _____

Your Daytime Phone: _____

☐ Check here if you are currently a resident of a Medi-Cal funded residential treatment program.

Current Provider: _____

If Applicable, Person Representing You: _____

Their Address: _____

Their Daytime Phone: _____

What is the problem?_____

What would you like the solution to be?

Whom have you talked to about the problem?

_____ _____

Client (or Client's Representative) Signature **Date**

You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance. Your confidentiality will be protected at all times in accordance with State and Federal law. You may request a State Fair Hearing following the completion of the Appeals or Grievance Process.

Riverside County Mental Health Plan
Authorization for Release of Information from the Medical Record

Client's Last Name	First Name	Middle Name	Date of Birth

Street Address	City	Zip Code	Telephone Number

==========

I, the undersigned, herby authorize (Name and address of health care service provider with records.)

_____
Health Care Provider Name

_____
Street Address

_____
City State Zip Code

And to: **Riverside County Mental Health Plan**
Quality Improvement (QI)
P.O. Box 7549
Riverside, CA 92513

access to my medical records for the purpose of _____.
I further authorize you to provide such copies thereof as may be requested.

The authorization is subject to the following limitations:

☐ 1. Confined to records regarding treatment for the period from _____
_____ to _____ .

☐ 2. Confined to records regarding admission and treatment for the following medical condition or injury: _____
_____ .

☐ 3. Confined to the following specified information: _____

_____ .

☐ 4. All medical records.

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate three (3) months from the date of consent without express revocation.

_____

Signature of Client, Legal Guardian, Representative (Please Circle)

_____

Date

_____

Signature of Witness

_____

Date

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.