WE TRY TO do our best in working with both consumers and providers, but we understand that sometimes things do not work out as planned. You may file an appeal if the Fresno County Mental Health Plan or one of it's contract providers does one of the following:

- denies or limits the authorization of a requested service, including the type or level of service,
- reduces, suspends, or terminates a previously authorized service,
- denies, in whole or in part, payment for service,
- fails to provide services in a timely manner, and
- fails to act within the time frames for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

If you would like to file an appeal, please fill out the appeal form and mail it to:

Fresno County Mental Health Plan
P.O. Box 45003
Fresno, California 93718-9886

If you are a Medi-Cal beneficiary, you have the right to request a State Fair Hearing once the appeal process has been completed.

OMBUDSMAN SERVICE
1-800-896-4042

PATIENTS' RIGHTS ADVOCATE
(559) 492-1652

FRESNO COUNTY
MENTAL HEALTH PLAN
1-800-654-3937

Appeals
English 07/2017

APPEALS

FRESNO COUNTY
MENTAL HEALTH PLAN
1-800-654-3937

APPEAL FORM

Date:_____

Site:_____

IF YOU SUBMIT an appeal to the Fresno County Mental Health Plan about your mental health services, you should send the appeal form to:

Fresno County Mental Health Plan
P.O. Box 45003
Fresno, California 93718-9886

Forms and stamped, addressed envelopes are available at all mental health service sites.

You may submit an oral appeal, but it must be followed by a written copy of the appeal or we will not be able to process it.

You should receive a written response within 30 days after we receive your appeal. If you have any questions or want to know the status of your appeal, please call:

1-800-654-3937

For hearing impaired, dial **711** to reach the California Relay Service.

EXPEDITED APPEAL. You or your representative may orally request that your appeal be addressed within 72 hours if a delay in services will jeopardize your life, your health, or your ability to attain, maintain, or regain maximum functioning. If you wish to submit in writing, please indicate on the appeal form why you are requesting an expedited appeal.

Thank you for taking the time to notify us.

Name:_____

Address:_____ Zip_____

Telephone:_____ (home) _____(work)

Primary language spoken:_____ Date of birth:_____

Reason for Appeal:_____

_____

_____

_____

How do you think that we should resolve this?_____

_____

_____

Signed:_____

Is this an expedited appeal? ____Yes ____No

If yes, please state the reason you believe this appeal needs to be expedited.

_____

_____

If you helped complete this form, please print your name:_____

What is your relationship to this consumer?_____