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

State Fair Hearings

Medi-Cal members may have concerns addressed at any State Fair Hearing after completing 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.

QUALITY IMPROVEMENT PROGRAM
P.O. BOX 7549
RIVERSIDE, CA 92513

Riverside University HEALTH SYSTEM Behavioral Health

RUHEALTH.ORG

This document is available in alternative formats upon request. If you are in need of a reasonable accommodation, please contact Riverside University Health System-Behavioral Health at 951-358-4500.

Rev. 6.18.26

Riverside University HEALTH SYSTEM Behavioral Health

RIVERSIDE COUNTY MENTAL HEALTH PLAN

APPEAL GRIEVANCE PROCEDURE & REQUEST FORM

RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH APPEAL & GRIEVANCE PROCEDURE

A member and/or member's representative may file an appeal or grievance, orally or in writing, with the Quality Improvement Program. If desired, they may request their service provider or the C.A.R.E.S. Team for assistance.

An **Appeal** is a request to review Adverse Benefit Determination, which is defined as the denial or limited authorization of a requested service, including reductions, suspensions, or terminations of previously authorized services. This includes reductions, suspensions, or terminations of services that were previously approved. The appeal process enables beneficiaries to contest coverage decisions, particularly regarding medical necessity or appropriateness.

A **Grievance** is defined as an expression of dissatisfaction not involved in an Adverse Benefit Determination. Examples of grievances include issues like poor service, discrimination, or delays in care, distinct from appeals, which contest benefit denials.

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 immediately orally and in writing within two calendar days. A denied Expedited Appeal may be filed as a standard Appeal.

Enclosed is an Appeal/Grievance Request Form for the member and/or member's representative to use to file a written Appeal or Grievance, which can be filed at any time. Grievance acknowledgement is within 5 calendar days from filing date and resolution timeframe is within 30 calendar days . Appeals will be resolved in accordance with the member's health condition, adhering to a standard timeline of 30 days from the receipt of the appeal.

Appeals may be filed by a member, or a provider and/or authorized representative, either orally or in writing. Appeals filed by the provider on behalf of the member require written consent from the member.

If you need assistance completing the form, you can request help from your provider or by calling the Quality Improvement Program at 800-660-3570, Patients' Rights at 800-350-0519, or locally at 951-358-4600.

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

You have the right to a DHCS State Hearing to challenge decisions regarding Medi-Cal eligibility, services, or benefits within 120 days from the date of the notice of appeal resolution.

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 member notified: _____
Outcome: _____

APPEAL/GRIEVANCE REQUEST

This form is used to file an Appeal or Grievance. If you need any 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 at (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 or 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 your Appeal or Grievance outcome.

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	Phone Number

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

Healthcare 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:

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

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

☐ Confined to the following specified information: _____ _____

☐ All medical records.

This consent is subject to revocation by the undersigned at any time 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.