

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

State Fair Hearings

Medi-Cal consumers 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 COUNTY MENTAL HEALTH PLAN

APPEAL GRIEVANCE PROCEDURE & REQUEST FORM



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 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 consumer and/or consumer's representative to use to file a written Appeal or Grievance. 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.

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 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
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 <i>(Name and address of health care service provider with records.)</i>			
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.