BEHAVIORAL HEALTH, SUBSTANCE USE TREATMENT SERVICES BENEFICIARY GRIEVANCE AND APPEAL FORM

If you have any problems with your substance use treatment services (SUTS), you are encouraged to discuss your concerns with your provider/program. However, you may file a formal grievance or appeal at any time either verbally or in writing using this form or by contacting the Managed Care Plan (MCP) at the **Beneficiary number (408) 792-5666**. You may also mail this form using the self-addressed envelopes at your provider's facility.

☐ **Grievance** ☐ **Appeal** ☐ **Expedited Appeal**

Name:_____ Date of Birth:_____

MRN#:_____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Legal Guardian/Parent/Conservator (if applicable):_____

Name of Agency/Staff Person Providing Service: _____

1. Describe the problem or issue:

2. What, if anything, have you already done to resolve the problem?

3. How would you like to see this problem resolved?

Beneficiary Signature: _____ Date: _____