

**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: \_\_\_\_\_