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KERN BEHAVIORAL HEALTH & RECOVERY SERVICES
PO BOX 1000
BAKERSFIELD CA 93302-9961

Kern Behavioral Health & Recovery Services Mental Health Plan and
Drug Medi-Cal Organized Delivery System

Appeal Form

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination.

Action: Occurs when the Local Mental Health and Drug Medi-Cal Organized Delivery System Plan

- Denies or limits authorization of a requested services;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to act within the required timeframes for standard resolution of grievances and appeals; or
- Denies a beneficiary's request to dispute financial liability.

Appeal: A request by the beneficiary or his/her representative for review of an adverse benefit determination.

Expedited Appeal: A request by the beneficiary to review an adverse benefit determination when using the standard resolution process could jeopardize the beneficiary's mental health or substance use disorder condition and/or the beneficiary's ability to attain, maintain, or regain maximum function.

FOLD FORM ONLINE, REMOVE COVER FROM TAPE, SEAL AND MAIL

Kern Behavioral Health & Recovery Services

ACTION APPEAL FORM

NOTE: Filing an Appeal following an **Adverse Benefit Determination** shall not adversely affect your services with **Kern Behavioral Health Recovery Services**. Beneficiaries must file an appeal with (60) sixty calendar days from the date of the Notice of Adverse Benefit Determination. Beneficiary services will respond with a Standard Appeal resolution within (30) thirty calendar days for the Standard Appeal or no longer than 72 hours for the Expedited Appeal. If the Expedited Appeal is denied, a written notice will be sent to the beneficiary and the Standard Appeal process will begin.

Please check the appropriate box: ☐ Standard Appeal ☐ Expedited Appeal

FORM TO BE COMPLETED BY BENEFICIARY / CLIENT AND FORWARDED TO THE PATIENT'S RIGHTS OFFICE
PO BOX 1000, Bakersfield, CA 93302-1000
Phone (844) 360-8250

Date: Service Location:

Beneficiary / Client
Name: Date of Birth: Ethnicity:

Gender: ☐ M ☐ F Preferred Language:

If client is a minor, then name of legal guardian filing on behalf of minor:

Address (include City / State / Zip):

Phone:

Did you receive a Notice of Adverse Benefit Determination? ☐ Yes ☐ No
Did you receive an action as defined as one the following?

1. Denies or limits authorization of a requested service;
2. Reduces, suspends, or terminates a previously authorized service;
3. Denies, in whole or in part, payment for a service;
4. Fails to provide services in a timely manner as determined by the Plan;
5. Fails to act within the required timeframes for standard resolution of grievances and appeals; or
6. Denies a beneficiary's request to dispute financial liability.

If yes, what would you like to see happen to resolve this Appeal?

_____

_____

_____

_____

Beneficiary Signature_____ Date:_____