

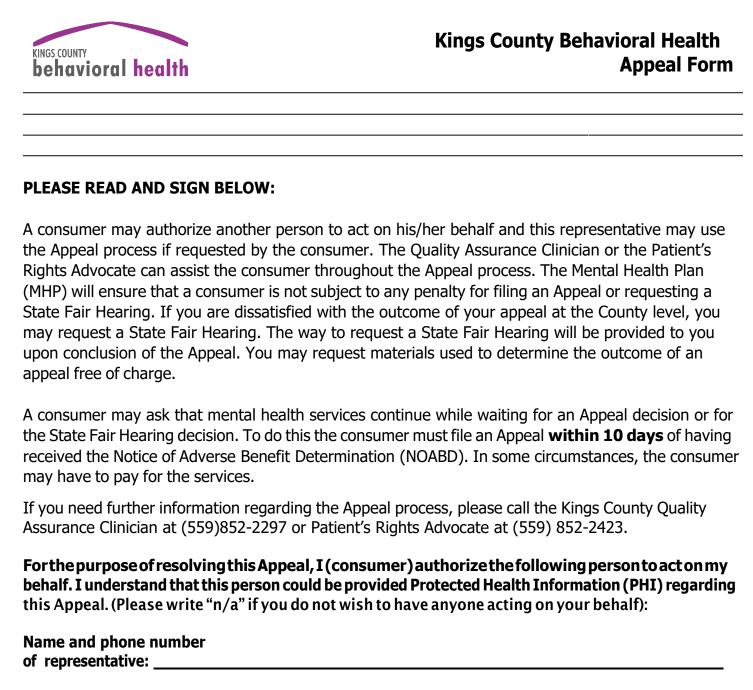
Kings County Behavioral Health Appeal Form

Note: Filing an appeal shall not adversely affect your services with Kings County Behavioral Health Mental Health Plan or network providers.

- You have 60 days to file this Appeal; the 60 days started the day after an Adverse Benefit Determination was given or mailed to you.
- Remember, you need not have received an Adverse Benefit Determination in order to file an Appeal. If you are unsure if this applies to you, you may ask any Mental Health staff member, or call the number below to request assistance:
 - 1. Quality Assurance Clinician: 559-852-2297

	Please print or write legibly.
Date	: Service location:
Clien	t Name: Date of Birth:
	ent is a minor, enter the name gal guardian filing on behalf of minor:
Addr	ress (City/ State/Zip)
Phor	ne Number (please indicate best time to call):
	d like for my information to remain anonymous.
	Describe the reason(s) for requesting an appeal. Please be specific by including names, dates, and times whenever possible.
Date 1.	of NOABD issuance: Describe the nature of your appeal. Attach additional pages if necessary:

2. What would you like to see happen to resolve this appeal? Attach additional pages if necessary:



I (consumer) also understand that the Quality Assurance Clinician (or designee) will be authorized to contact my representative (as named above) and any involved provider in order to resolve my Appeal. The Quality Assurance Clinician (or designee) will also be authorized to discuss any and all information that shall be needed to evaluate and resolve this Appeal.

Signature of person	
making this appeal:	Today's date :

Submit your form:

Mail: 1400 W. Lacey Blvd. Build 13 Hanford, CA 93230 In Person: 1222 W. Lacey Blvd. 2nd Floor Hanford, CA 93230 Email KCNOABD@co.kings.ca.us or Fax (559) 852-4219