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Kern Behavioral Health & Recovery Services
PO Box 1000
Bakersfield CA 93302-9961

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

Appeal Form

Appeal: An appeal is a request for review of an Adverse Benefit Determination. An "Adverse Benefit Determination" includes, but is not limited to:

- Denial, or limited authorization of a requested service, including the type of level or service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as determined by Plan;

- Failure to act within required timeframes for standard resolution of grievances and appeals; or
- Denial of a beneficiary's request to dispute financial liability.

Note: Filing an Appeal following an Adverse Benefit Determination shall not adversely affect your services with Kern Behavioral Health & Recovery Services.

You may file an appeal within 60 calendar days from the date of the Notice of Adverse Benefit Determination.

An appeal may be submitted orally or in writing by the beneficiary, a provider, or an authorized representative. A provider filing an appeal on behalf of a beneficiary must obtain the beneficiary's written consent.

You will receive written acknowledgement of your appeal within 5 calendar days of receipt.

Standard Appeals
Standard appeals will be resolved within 30 calendar days from receipt of the appeal.

Expedited Appeals
An expedited appeal may be requested if the beneficiary, or the beneficiary's provider, certifies that waiting for a standard appeal resolution could seriously jeopardize your life, physical health, mental health or substance use disorder condition and/or ability to attain, maintain, or regain maximum function.

Expedited appeals will be resolved no later than 72 hours from the date and time of the expedited appeal receipt, unless an extension is permitted by law.

State Fair Hearing Rights

You have the right to request a State Fair Hearing if:

- You disagree with the appeal resolution;
- The Plan does not resolve your appeal within required timeframes; or
- Other conditions established by state or federal law are met.

A request for a State Fair Hearing must be submitted within 120 calendar days from the date of the Notice of Appeal Resolution.

Please note: The County's Grievance & Appeal System must be exhausted, prior to the requesting of a State Fair Hearing. It is intended to resolve problems in the most prompt, efficient and effective manner possible. For assistance with filing an appeal, or State Fair Hearing request, contact **1-844-360-8250.**

Kern Behavioral Health & Recovery Services
Appeal Form

Written: Drop off completed form to any clinic location, or the "Fee-for-Service" Provider, or mail completed form to:

Kern Behavioral Health & Recovery Services
Office of Patients' Rights
P.O. Box 1000
Bakersfield, CA 93302-1000

Oral: Call 1-844-360-8250; or report to the supervisor at any clinic location, or "Fee-for-Service" Provider

Date: _____Beneficiary Name:_____

Date of Birth: _____Ethnicity:_____

Gender_____

Preferred Language: _____ Phone Number: _____

Address: _____

City/State: _____ Zip Code: _____

Using Authorized Representative? ☐ Yes ☐ No
If "Yes", complete below
Representative Name:
Representative Phone:
Relationship to Beneficiary:

Did you receive a Notice of Adverse Benefit Determination?

☐ Yes ☐ No

Did you receive an action as defined as one of the following?

- ☐ Denial, or limited authorization of a requested service;
- ☐ Reduction, suspension, or termination of previously authorized service;
- ☐ Denial, in whole or in part, of payment for a service;
- ☐ Failure to provide services in a timely manner, as determined by Plan;
- ☐ Failure to act within required timeframes for standard resolution of grievances and appeals; or;
- ☐ Denial of a beneficiary's request to dispute financial liability.

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

_____

_____

_____

Please check the appropriate box:

☐ Standard Appeal ☐ Expedited Appeal

Beneficiary's Signature: _____

Date: _____