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



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

Grievance: An expression of dissatisfaction about any matter related to your services that is not an Adverse Benefit Determination.

- You may file a grievance at any time.
- A grievance may be submitted orally or in writing.
- A grievance may be filed by the beneficiary, a provider acting on behalf of the member, an authorized representative, or a parent or legal guardian, when applicable.

- If a grievance is filed on your behalf by an authorized representative or provider, documentation authorizing representation may be required.
- You will receive written acknowledgment of your grievance within 5 calendar days of receipt.
- The Plan will resolve your grievance within 30 calendar days of receipt.



Kern Behavioral Health & Recovery Services Grievance 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 grievance to the supervisor at any service site

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 Phone:

Representative Name:

Relationship to Beneficiary:

Date of Incident: _____

Name of the provider/program this grievance is against:

1. Please describe your concern. Include dates, names, locations, and any other information you believe may be helpful.

2. What would you like to see happen to resolve this grievance?

Beneficiary's Signature: _____

Date: _____