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	Expedi	ted Appeal
Name:		Date of Birth:	
MRN#:	Phone:		
Address:	City:	State:	Zip:
Name of Legal Guardian/Parer	nt/Conservator (if applicable):_		
Name of Agency/Staff Person	Providing Service:		
1. Describe the problem of	or issue:		
2. What, if anything, have	e you already done to resolve th	he problem?	
3. How would you like to	see this problem resolved?		
Beneficiary Signature		Date:	