PM FORM 5.3.1
ADHS/DBHS APPEAL OR SMI GRIEVANCE FORM

Print Form

Member/Applicant Information:

Name (Last, First, M.I.) | Date

Address | City | State

Zip code | Phone | Date of Birth

Information about the person filing (if different than above):

Name (Last, First, M.I.)

Address | City | State

Zip code | Phone

Relationship to the Member/Applicant (i.e. Provider, Parent or Guardian)

Description of Appeal or Grievance: (Please include dates, names, locations, also any other attempts to resolve the problem, attaching additional pages as necessary.)

What solution do you want?

Continuation of Services:

For members with a Serious Mental Illness, your services under appeal will be continued during the appeal process, unless doing so poses a serious threat of harm to you or others.

For appeals relating to Title XIX or XXI services, please check *one* of the following:

☐ I am requesting that the services I am appealing be continued during the appeal process. I understand that if I lose my appeal, I may be required to pay for the cost of the services that were continued during the appeal process.

☐ I do not want the services I am appealing to be continued during the appeal process.

Client Signature | Date:

Provider, Parent or Guardian Signature | Date:

Last revision Date: 05/24/2009
Last effective Date: 07/01/2009