

APPEAL – INSTRUCTIONS

The Department of Public Health Substance Abuse Prevention and Control (SAPC) is the specialty substance use disorder plan for the County of Los Angeles. While receiving substance use disorder treatment, you have the right to use SAPC’s problem resolution process.

HOW THE PROBLEM RESOLUTION PROCESS WORKS - APPEALS:

If you are a Medi-Cal beneficiary (meaning you are currently enrolled in Medi-Cal) you have the right to file an appeal when you receive a Notice of Adverse Benefit Determination (NOABD) from SAPC or your substance use disorder treatment provider.

An NOABD is a document given to Medi-Cal beneficiaries telling them about a denial or change in services. If you disagree with a decision in the NOABD, you can file an appeal with SAPC. That means you can ask for the decision to be reviewed and possibly changed. If you request a standard appeal, SAPC may take up to 30 calendar days to review. If you think waiting 30 calendar days will put your health at risk, you may ask for an expedited appeal which, if it meets certain criteria, will be reviewed within 72 hours of receipt.

If you receive a NOABD and want to appeal the decision:

* Your request for an appeal must be received within 60 calendar days from the date of the original decision.
* You may request an “expedited” appeal under extreme circumstances.
* You will not be subject to discrimination or any other penalty.
* Your confidentiality will be protected according to government laws (*W&I 5328* and *42 CFR Part 2*).

Appeals filed without the patient’s involvement, including appeal forms filed without the patient’s written consent, must include a written justification for why the patient was unable to be involved with filing the appeal. Appeals filed without the patient’s involvement will be processed as a complaint/grievance in accordance with SAPC complaint/grievance protocols.

After you submit this form (see Page 2), if you disagree with the decision made about your appeal, you can request a State Fair Hearing. A State Fair Hearing is an independent review conducted by the State Department of Social Services. You must make the request within 120 days from the date you received the appeal decision. If you are currently in treatment and want to continue while you appeal, you must ask for a State Fair Hearing within 10 days from the date of appeal decision. If you need assistance requesting a State Fair Hearing, ask your treatment provider or call SAPC at 1-888-742-7900.

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| **To request a State Fair Hearing on your own** |
| Write to: | State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430 | Call: 1 (800) 952-8349 |

If you want to have a complaint or decision about your care reviewed again, but did not receive an NOABD, please file another “Complaint/Grievance” Form.

**For more information on the problem resolution process, please refer to your patient handbook or visit us at** [**http://publichealth.lacounty.gov/sapc/PatientPublic.htm**](http://publichealth.lacounty.gov/sapc/PatientPublic.htm)**.**



APPEAL FORM

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| 1. (**Check One**): Standard Appeal Expedited Appeal | 2. Date: |
| **INFORMATION ABOUT MEDI-CAL BENEFICIARY FILING APPEAL** |
| 3. Name (Last, First, and Middle):*(required)* | 4. Sage Patient ID#: *(if known)* | 5. Authorization #*(if known)* |
| 6. Date of Birth:*(required)* | 7. Medi-Cal #:*(if known)* | 8. Street Address:*(required if there is an address available)* |
| 9. City and Zip Code*(required if there is an address available)* | 10. Phone Number and/or Email Address: *(required if there is a phone number or email address available)* | 11. Do we have your permission to leave a voice message? Yes No |
| **COMPLETE IF AUTHORIZING A REPRESENTATIVE TO APPEAL ON YOUR BEHALF** |
| 12. Name of Representative: | 13. Agency Name/ Relationship: | 14. Email: |
| 15. Street Address: | 16. City and Zip Code: | 17. Phone: |
| 18. **If the Patient is authorizing another person or entity to represent them in filing this appeal, their signature is required below**. **Appeals filed without this signature must include a written justification for why the patient was unable to be involved with filing the appeal.** |
|  Patient Name (Print) Patient (Signature) |
| **INFORMATION ABOUT THE APPEAL** |
| 19. Did you receive a Notice of Adverse Benefit Determination (NOABD) letter? Yes No |
| 1. Did anyone complete this form on your behalf? Yes No
 |
| 1. Which type of NOABD did you receive:
	* Denial  Termination
	* Payment Denial  Timely Access to Services
	* Other, describe:  Notice of Grievance/Appeal Resolution
 |
| 22. Please provide detailed information on your appeal of the NOABD. Attach pages and documentation, if needed. |
| 1. Facility Site Address related to Appeal:
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**Signature of Medi-Cal Beneficiary/Authorized Representative Date**

**SUBMIT THE COMPLETED APPEAL BY:**

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| **Email:** **SAPCmonitoring@ph.lacounty.gov** | **Mail: Substance Abuse Prevention and Control, Contracts and Compliance Branch, 1000 South Fremont Avenue, Building A9 East, 3rd floor, Box 34, Alhambra, California 91803** |
| **Phone: (626) 299-4532** |
| **Fax: (626) 458-6692** |
| **If you need this form in alternate format (e.g., large print, braille, or audio), call 1-888-742-7900 press 7.** |