

# APPEAL FORM

Date \_\_\_\_\_

**Who can use this form?** This form is for persons with Oregon Health Plan insurance whose mental health plan is Mid-Valley Behavioral Care Network (MVBCN).

**When to use this form.** You can use this form if you received a Notice of Action about your mental health services and want to have that decision reviewed. *This is called filing an Appeal.* Fill out both pages of this form and sign it on page 2. Return the completed form to the MVBCN office at the address listed on page 2.

**Need more information about filing an Appeal?** Refer to the MVBCN document called “How to File an Appeal” or contact the MVBCN office.

**PART 1** If you are filing this Appeal for yourself, fill in *your* information. If you are filing this Appeal for someone else, fill in *that person’s* information.

Full Name	_____	Oregon Health Plan ID #	_____
	_____	Date of Birth	_____
Mailing Address	_____	Main Phone #	_____
	_____	Alternate Phone #	_____

**PART 2** If you are filing this Appeal for the person listed in Part 1, fill in *your* information.

*Important note:* If you are not an authorized Member Representative for the person listed in Part 1, that person must sign an authorization form to give permission for you to file this Appeal.

Full Name	_____	What is your relationship to the person listed in Part 1? This person is my:	_____
	_____		_____
Mailing Address	_____	Main Phone #	_____
	_____	Alternate Phone #	_____

**PART 3** Answer the questions below. Use more paper if needed.

1. Did you receive a Notice of Action about the services for the person listed in Part 1?

MARK ONE:

**YES** If you marked YES: Answer questions 2, 3 and 4.

**NO** If you marked NO: You must use the OHP Complaint Form. Contact the MVBCN office on page 2 to ask for this form.

2. Explain why you want to have the decision in the Notice of Action reviewed.

Continued on page 2 ➡

You can get this form in a larger print size or in a different format. You can also get this form in some languages other than English. Contact the MVBCN office to ask for this.

**PART 3 Continued from page 1**

3. Do you want the services for the person listed in Part 1 to continue while the decision is being reviewed?

MARK ONE:       DOES NOT APPLY       YES       NO

*If you marked YES: If services are continued, the person listed in Part 1, or his/her authorized Member Representative, may be required to pay for the cost of services if the Appeal decision is not in the person's favor.*

4. For the person listed in Part 1, do you feel that his or her life, health or ability to function is in serious jeopardy?

MARK ONE:       YES       NO

*If you marked YES: Call the MVBCN office right away at the phone number listed below to request an Expedited Appeal. If the situation meets the conditions to be handled as an Expedited Appeal, the Appeal decision will be made within 3 working days instead the standard 16 calendar days.*

*You do not need to fill out this form if the situation meets the conditions to be handled as an Expedited Appeal. If your request for an Expedited Appeal cannot be approved, then the Appeal will follow the standard process. For the standard Appeal process, you must sign this form.*

**PART 4 Signature/s**

\_\_\_\_\_  
Signature of the person listed in Part 1

\_\_\_\_\_  
Signature of the person listed in Part 2

**Please read the section below before signing this form.**

You must sign this form in order to file the Appeal. If someone else is filing the Appeal for you, then that person's information must be listed in Part 2 and both of you must sign this form.

Your Appeal will be kept confidential. This is required by federal and state laws and rules. Only MVBCN, the treatment agency, your provider and/or the Addictions and Mental Health Division of the Oregon Department of Human Services can look at, share and discuss your confidential information. They can do this to investigate and resolve your Appeal. They can do this also for certain other required purposes. You don't need to sign an authorization form for this.

You can have someone else file the Appeal for you. If this person is an authorized Member Representative, you don't need to sign an authorization form. They can look at, share and discuss your confidential information to help investigate and resolve your Appeal. If the person is not an authorized Member Representative, then you must sign an authorization form.

**Important notes:**

- *If you are 14-17 years old and have consented to mental health treatment without involving your parent or legal guardian, you can file this form without anyone else's signature.*
- *If you are a parent or legal guardian and the person listed in Part 1 is under 18 years old, you can sign this form without that person's signature. The exception is if the person is 14-17 years old and has consented to mental health treatment without involving a parent or legal guardian.*
- *If there is any other reason why you have authority to file this Appeal without the signature of the person listed in Part 1, you must provide proof of this when filing the Appeal.*

**Where to return this form**

Mid-Valley Behavioral Care Network  
Attn: Appeals  
1660 Oak Street SE, Suite 230  
Salem, Oregon 97301

**Call if you need help filling out this form:**

In Salem: 503-361-2647  
Toll-free: 1-866-422-6647  
*Oregon Telecommunications Relay Service:*  
TTY or Voice: 711 • VCO: 1-800-735-3260