APPEAL REQUEST FORM

1. Is the enrollee or a provider requesting this appeal? ☐ Enrollee ☐ Provider
2. Enrollee's Name:____

   Enrollee's Address:____
3. Provider's Name:____

   Provider's Address:____
4. The Reason You are Requesting the Appeal:

   ____
   ____
   ____
   ____
   ____

5. You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.

   ☐ Check here if you want an expedited Appeal.
6. If the Appeal is about decreasing or ending services, do you want these services continued during the Appeal process? Please remember if the Appeal decision is not in your favor, you may have to pay for these services.

   ☐ Check here if you want these services continued.

If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call OptumHealth at (877) 370-8953. If you believe Optum has not answered your questions or assisted you like you wanted, then please contact the Quality Assurance Manager at Salt Lake County Division of Behavioral Health Services at (801) 468-2009.

REMINDER

Please mail the completed form to:

Salt Lake County Division of Behavioral Health Services
Mental Health Quality Assurance Manager
2100 South State Street, Suite S-2300
Salt Lake City, UT 84190-2250

If you are **not** asking for an expedited (quick) appeal, and you call the Salt Lake County Division of Behavioral Health Services first to file your appeal, you must send this form to the Salt Lake County Division of Behavioral Health Services within 5 working days of your call, or you lose the right to appeal.

Provider Permission Statement

If your provider is filing the Appeal for you, you must give your written permission.

I ____ (print your name) permit _____________________________________ (print provider's name) to file this appeal for me.

____ __________________

Enrollee's Signature Date