County of Inyo
Health & Human Services Department
Behavioral Health

Member Expedited Appeal Form

This form is to be used to if you disagree with a Notice of Adverse Benefit Determination (NOABD) issued by Inyo County Behavioral Health (ICHB) and waiting for a standard appeal decision could seriously jeopardize your life, Physical Health, Mental Health and Ability to attend, maintain or regain maximum functioning.

WHAT YOU NEED TO KNOW

Dissatisfaction with Adverse Benefit Determination (NOAB)?

If your concern involves a Notice of Adverse Benefit Determination (NOABD), you have the right to file an appeal instead of a grievance.

Who can file and how?

A member, an authorized representative or provider may file an expedited appeal on the member's behalf either orally or in writing.

To file an Appeal:

You can file your appeal verbally by calling 760-873-6533 and tell staff that you would like to file an appeal verbally. You can also, fill out this form and mail or drop off at Health and Human Services Office or email it to inyobh@inyocounty.us or fax it to 760-873-3277.

- Bishop Office
  1360 N. Main Street, Bishop, CA 93514
- Lone Pine Office
  310 N. Jackson, Lone Pine, CA 93545

Free interpreter services, translated materials, and auxiliary aids are available upon request. If you need this form in another language or format, please contact Inyo County Behavioral Health.

What happens after you file?

- We will issue a decision within 72 hours if the appeal qualifies for expedited review. If it does not qualify then standard appeal timeframe of 30 days will be used.

MEMBER INFORMATION

Member Name:	Date of Birth:
Medi-Cal ID: (if known)	Email:
Mailing Address:	Phone:
Member's Preferred Method of Communication: ☐ Email ☐ Phone ☐ Mail ☐ Other	

Person Filing Appeal

☐ Self ☐ Provider ☐ Authorized Representative: _____

Member Language Preference:

☐ English ☐ Spanish ☐ Other: _____

Do you need an Interpreter? ☐ Yes ☐ No

APPEAL INFORMATION

Date of NOAB: _____ **Date NOAB Received:** _____	**NOAB Decision:** ☐ Denial ☐ Reduction ☐ Suspension ☐ Delay ☐ Termination ☐ Payment Denial ☐ Other: _____

What outcome would you like?

Why should this appeal be expedited?

Supporting Information: (optional)

Provider Name: _____ Provider Phone: _____

Provider Statement Attached? ☐ Yes ☐ No

PERSON FILING APPEAL

Print Name: _____

Signature: _____ Date: _____