WE TRY TO do our best to help. If you are not satisfied with a Notice of Adverse Benefit Determination "NOABD", you can request an appeal. You must request an appeal within 60 calendar days from the date on the NOABD.

HOW TO REQUEST AN APPEAL:

You must receive a NOABD before you request an appeal. You can complete this form and mail it to:

Fresno County
Department of Behavioral Health
P.O. Box 45003
Fresno, California 93718-9886

You can pick up a form and envelope at any provider site.

You can call 1-800-654-3937 to request an appeal. You must also mail a written copy of the appeal.

You will receive a letter as soon as we receive your appeal. You will receive a decision letter within 30 calendar days. You can request a decision within 72 hours if waiting 30 days could risk your life, your health, or your ability to reach, continue, or recover maximum functioning .

You will not be discriminated or retaliated against. We can help you with the form. We can guide you through the process. We can provide support services, such as an interpreter. If you have trouble speaking or hearing, please call 711 for help.

YOUR STATE FAIR HEARING RIGHTS:

If you do not agree with an appeal decision or if you do not receive a decision letter, you can request a hearing.

You must request a hearing within 120 days from the day you receive the NOABD. You can request a hearing from:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
(800) 952-5253

.

Appeal Brochure
English 08/2020

APPEAL FORM

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
1-800-654-3937

APPEAL FORM (Please print)

Please print the following regarding the individual submitting the appeal: ☐ Self ☐ Family ☐ Other _____

Last Name:	First Name:	M.I:	This appeal is related to: ☐ Mental Health Services ☐ Substance Use Disorder Service

Date of Birth:	Daytime Phone Number: ( )	Message Phone Number: ( )	Preferred Language:

Address:	Unit #	City/State:	Zip Code:

If you helped complete this form, please print your name:	Relationship to the person served:

Information about your appeal as it relates to the Notice of Adverse Benefit Determination (NOABD) you received:

Name of the provider/program who issued the NOABD:	Reason why NOABD was issued:	Date of NOABD:

Reason for the Appeal (Be specific: Who, What, When, Where, Why, How, etc.) You may attach additional pages, if needed.

Are you requesting this appeal be resolved within 72 hours because waiting 30 days could risk your life, your health, or your ability to reach, continue, or recover maximum functioning ? ☐ Yes ☐ No. If yes, explain below:

Print Name (Individual who received NOABD):	Signature (Individual who received NOABD):	Date: