APPEAL REQUEST FORM

1. Is the Medicaid member or a provider requesting this appeal? ☐ Member

   ☐ Provider

2. Member's Name:_____

   Member'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. You may also ask for a quick decision if you believe taking the normal amount of time might cause you to have a long term 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 please call Optum at (877) 370-8953. If you believe Optum has not answered your questions or helped you like you wanted, then please call the number below.

Salt Lake County Division of Behavioral Health Services – Quality Assurance Manager: (385) 468-4707

REMINDER

Please mail the completed form to:

Salt Lake County Division of Behavioral Health Services
Quality Assurance Manager
P.O. Box 144575
2001 South State Street, Suite S2-300
Salt Lake City, UT 84114-4575

If you are **not** asking for a quick appeal, and you call the Salt Lake County Division of Behavioral Health Services first to file your appeal, you must send this form in within 5 working days of your call.