Sonoma County Department of Health Services- Behavioral Health Division

Provider Problem Resolution & Payment Appeal Form

Please attach written statements, chart documentation, and any other materials in support of your appeal.

All e-mail communications containing member identification or other protected health information must be encrypted to ensure the security of transmitted electronic health information.

Return completed form by:

Mail:
Sonoma County Behavioral Health Plan
Administration ATTN: Provider Relations
2227 Capricorn Way
Santa Rosa CA 95407

or

Phone: (707) 565-4767
Fax: (707) 565-2202 ATTN: Provider Relations
E-mail: SCBHProviderRelation@sonomacounty.gov

Date:	

Provider Name:		Program Name:	

Contact Person:		E-mail:	

Phone:		Best time(s) to call:	

Name of Member/Consumer:		Member ID #:	

Date(s) of service involving this complaint or appeal:	

For Provider Concerns/Complaints (select all that apply):

☐ Issues related to provider contracts including, but not limited to, payment agreement, scope of work, etc.
☐ Disagreement with monitoring/audit review findings by DHS-BHD Quality Assurance staff
(Appeals are due **within 15 calendar days** of the Provider's receipt of findings/audit report)
☐ Disagreement with service decisions made by DHS-BHD staff
☐ Other concerns/complaints:

For Provider Appeals of Payment (select all that apply): *All appeals must be received in writing by DHS-BHD Provider Relations within 90 calendar days of receipt or fax date of notification of non-approval of payment, or within 90 calendar days of DHS-BHD's failure to act upon the request.*

☐ Denied request for payment
☐ Modified request for payment
☐ Dispute with DHS-BHD regarding processing or payment of a claim, including but not limited to, a delay of payment

Please explain:

Provider Signature:		Date:	
Print Name:			

(FOR DHS-BHD USE ONLY)

Received by DHS-BHD Provider Relations Date: _____

Received by the BHPA Date: _____

Recommendation: ☐ Approve ☐ Modify ☐ Deny Date: _____

Received by DHS and BHD Senior Date: _____

Decision: ☐ Approve ☐ Modify ☐ Deny Date: _____

DHS-BHD Provider Relations Response to Provider Date: _____