Sonoma County Behavioral Health: Mental Health Plan Administration

PROVIDER Problem Resolution & Payment Appeal Form

PLEASE ATTACH WRITTEN STATEMENTS, CHART DOCUMENTATION, AND ANY OTHER MATERIALS IN SUPPORT OF YOUR APPEAL. All email communications containing client identification or other health protected information must use encryption to secure transmitted electronic health information.

Return completed form by: Mail to: Sonoma County Mental Health Plan Administration
ATTN: Provider Relations
3322 Chanate Rd.
Santa Rosa CA 95404, or
Phone: (707) 565-4850 Provider Relations, or
FAX: (707) 565-4892 ATTN: Provider Relations, or
Email: SCBHProviderRelation@sonoma-county.org

DATE: ________________
PROVIDER NAME:___________________________ PROGRAM NAME:___________________________
CONTACT PERSON: _______________________________________________________________
EMAIL: ___________________________________________________________________________
PHONE: _________________________________ BEST TIME(S) TO CALL: __________________
NAME OF CLIENT/CONSUMER: ____________________________________________Client ID #: ___________
DATE(S) OF SERVICE: ______________________________

For Provider Concerns/Complaints:
☐ Issues related to provider contracts including, but not limited to, payment agreement, scope of work etc.
☐ Disagreement with compliance review findings by SCBH Quality Assurance staff
☐ Disagreement with service decisions made by SCBH staff
☐ Other issues:_____________________________________________________________________

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

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

PLEASE EXPLAIN:
____________________________________________________________________________________

PROVIDER SIGNATURE: ______________________________________ DATE:__________________
PRINT NAME__________________________________________________________________________

(FOR SCBH MENTAL HEALTH PLAN USE ONLY)
☐ Received by SCBH Provider Relations Date:_________
☐ Received by the MHP Administration Committee Date:_________
☐ Decision: ☐ Approved ☐ Modified ☐ Denied Date:_________
☐ MHP Response sent to Provider Date:_________

MHS 405 (12-16)
**Provider Problem Resolution Process:**

Provider concerns or complaints may be submitted to the Mental Health Plan (MHP) Provider Relations by telephone (707) 565-4850, in person, or in writing by using the Provider Problem Resolution & Payment Appeal form. The completed form may be returned by mail, or FAX (707) 565-4892 ATTN: Provider Relations, or Email to: SCBHPProviderRelation@sonoma-county.org.

All email communications containing client identification or other health protected information must use encryption to secure transmitted electronic health information.

The Provider Problem Resolution and Payment Appeal Processes form is located at http://www.sonoma-county.org/health/publications/contractors-all.asp

Provider concerns or complaints may address, but are not limited to the following issues:

- Issues related to provider contracts, including, but not limited to, payment agreement, scope of work, etc.
- Disagreement with compliance review findings by SCBH Quality Assurance staff
- Disagreement with service decisions made by SCBH staff
- Other issues not limited to above

Efforts will be made to resolve concerns/complaints at the lowest level of MHP involvement. When efforts to resolve concerns/complaints at an informal level have failed to achieve a resolution of the issue, Health Program Management staff will direct the provider to complete the Provider Problem Resolution and Payment Appeal form and return the completed form to SCBH Provider Relations.

**Provider Payment Appeal Process:**

Providers have the right to initiate the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun. The MHP will inform the provider whether initiating the Provider Problem Resolution Process will affect the provider’s timelines for accessing the Provider Payment Appeal Process.

Providers may file an appeal related to the following three reasons only:

- Denied request for payment
- Modified request for payment
- Dispute with SCBH concerning the processing or payment of a provider’s claim, including but not limited to, a delay in payment.

For appeals, providers must submit this completed form to the MHP Provider Relations within:

- (90) calendar days of the receipt or fax date of notification of non-approval of payment, or
- (90) calendar days of the MHP’s failure to act upon the request.

The MHP Administration Committee has (60) calendar days from receipt of the appeal to inform the provider in writing of the decision, including a statement of reasons for the decision, and any action required by the provider to implement the decision. If the MHP does not respond within (60) calendar days to the appeal, the appeal will be considered denied in full by the MHP. The MHP Administration Committee provides the final decision on payment appeals.

The MHP staff involved in the initial denial of the request for payment will not participate in the appeal review by the MHP Administration Committee.