APPEAL REQUEST FORM

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

   ☐ Member ☐ Provider

2. Member Name:_____

   Medicaid ID #:_____

   Member Address:_____

3. Provider Name:_____

   Provider 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.

Please see the timeframes for filing all types of appeals on the *Instructions for Filing an Appeal* form.

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

Please mail the completed form to:

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

Email: SLCoAppeals@saltlakecounty.gov

Fax: (385) 468-4740