Behavioral Health Department
Alameda County Health

Karyn Tribble, PsyD, LCSW
Director

GRIEVANCE/ APPEAL CALL FORM

Date and Time:	**Staff:**		**Beneficiary Insyst #**
Family: (Name/Relationship)	**Authorized Representative:**		**Provider:**
Beneficiary's Name:	**Medi-Cal #:**		**MHSA funding: Y or N**
Address:	**Birthdate:**		
	Medi-Cal #:		
Phone:	**Social Security #:**		
Provider Agency:	**Time of Grievance:**		
Program Name:	**Time of Grievance Resolution:**		
Form of Consent: Verbal Authorization Yes___ No ___		**Release of Authorization Form Received: Yes ____ No ____**	
Grievance:			
Grievance Resolution:			
Please fax completed form to BHD Quality Assurance office 510-639-1346.			