BEHAVIORAL HEALTH
QI-85 PROVIDER PROBLEM RESOLUTION REQUEST

(Please check one) ☐ Grievance ☐ Appeal

Provider Name: _____ Phone #: _____
Mailing Address: _____
Name and Title of Person Filing Grievance / Appeal: _____
Phone #: _____
Is this an appeal of a denied or modified request for services? Yes ☐ No ☐
Is this a dispute concerning the processing or payment of a claim? Yes ☐ No ☐

Description of Issue:

_____
_____
_____
_____
_____
_____
_____

Provider Signature: _____ Date: _____
(Attach documentation for request for authorization or denied / disputed claims)

Return form via email to MHB-QI_QA@co.humboldt.ca.us, fax to (707) 476-4096, or mail to Quality Improvement, 720 Wood Street, Eureka, CA 95501.
Call (707) 268-2955, option 1 with any questions.

DHHS-BH INTERNAL USE ONLY:
Resolution/Action Taken:

_____
_____
_____
_____
_____
_____
_____

Signature of Manager: _____ Date: _____