



**EMPOWERING PEOPLE ~ STRENGTHENING  
COMMUNITY**

**NON-MEDICAID SERVICE COMPLAINT FORM**

If you wish to file a complaint about or appeal the utilization management decision described in the enclosed decision letter, provide the information below and send the form along with the decision letter or a copy to Mental Health Partners no more than ten (10) days from the date of this letter. If the tenth (10<sup>th</sup>) day is on a weekend or a holiday, the deadline will be the next business day.

What is the local Utilization Management decision(s) you are appealing?

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Consumer's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Consumer's Date of Birth: \_\_\_\_\_ (month) \_\_\_\_\_ (day) \_\_\_\_\_ (year)

Consumer's Address: \_\_\_\_\_  
\_\_\_\_\_

Consumer's Telephone Numbers: \_\_\_\_\_ (day) \_\_\_\_\_ (evening)



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Name of Legal Guardian, if applicable: \_\_\_\_\_

Guardians' Address: \_\_\_\_\_

\_\_\_\_\_

Guardian's Telephone Numbers: \_\_\_\_\_ (day) \_\_\_\_\_ (evening)

Consumer or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send this form and a copy of the decision letter to:**      **Mental Health Partners**  
**Customer Service Unit**  
**1985 Tate Blvd. SE, Suite 529**  
**Hickory, NC 28602**