

Grievance Form

Please complete this form and return to the mailing address shown above at your earliest convenience. Receipt from you will be acknowledged within five working days. All grievances will be resolved within 30 days whenever possible. If your grievance is urgent or an emergency please call the Plan toll-free at **1-855-388-6257, TTY/TDD 711** for Los Angeles County or **1-833-479-1984, TTY/TDD 711** for Sacramento County for an immediate review. Members who file a grievance against the Plan will not be discriminated or retaliated against in any way.

Member Information

Member Name: _____

Member Identification #: _____

Subscriber Name (if different from above): _____

Subscriber Identification # (if different from above): _____

Day Phone: _____ Evening Phone: _____

Grievance Information

Please use the back side of this form to describe your grievance in detail.
This grievance is being filed against (please check the appropriate box(es)):

Plan Facility Facility Personnel

Date(s) Grievance Occurred: _____

Facility Information

Facility Name: _____ Facility Identification #: _____

Facility Address: _____

Treating Provider Name(s): _____

List the name(s) of facility personnel you spoke with about this matter: _____

Definitions for Grievance Procedures

- “Grievance” means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee’s representative.
- “Complaint” is the same as “grievance.”
- “Complainant” is the same as “grievant,” and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
- “Resolved” means that the grievance has reached a final conclusion with respect to the enrollee’s submitted grievance, and there are no pending enrollee appeals within the plan’s grievance system, including entities with delegated authority.
- “Pending” grievances that are not resolved within 30 calendar days, or grievances referred to the Department’s complaint or independent medical review system.

Cancellation of Healthcare Coverage Grievance Form

Member Information

Member Name: _____ Gender: Male Female Other

Parent/Guardian Name (if completed for a minor child): _____

Member Date of Birth: _____ Membership #: _____

Member Mailing Address: _____

Member City, State, Zip: _____

Day Phone: _____ Evening Phone: _____

E-Mail Address: _____

Employer (if applicable): _____

Name(s) of All Enrollees Effected: _____

Subscriber Identification #(s) of All Enrollees Effected: _____

Health Plan Name: _____

Medi-Cal Identification # (if applicable): _____

Medicare or Medicare Advantage ID # (if applicable): _____

Medical Group (if applicable): _____

Member Signature: _____ Date: _____

Grievance Information

If Applicable:

Date Member received notice that coverage was or will end: _____

Date Member filed a grievance with an entity other than the DMHC: _____

If Available, Please Provide:

- Copies of plan notice(s) and correspondence(s) received, if any
- Copies of any correspondence(s) sent by the Member
- Copies of proof of payment for the last paid coverage period

Authorized Assistant Form

If you want to give another person permission to assist you with your grievance, complete Parts A and B below.

If you are a parent or legal guardian submitting this grievance for a child under the age of 18, you do not need to complete this form.

If you are filing this grievance for an enrollee who cannot complete this form because the enrollee is either incompetent or incapacitated, and you have legal authority to act for this enrollee, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the enrollee.

Part A: Member

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my grievance will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Member Name (print): _____

Member Signature: _____ Date: _____

Part B: Person Assisting Member

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

Name of Person Assisting (print): _____

Signature of Person Assisting: _____

Street Address: _____

City, State, Zip: _____

Relationship to Patient: _____

Daytime Phone #: _____

Evening Phone #: _____

Email Address: _____

My power of attorney for health care decisions or other legal document is attached. (check if applicable)

Grievance/Compliant Form Instruction Sheet

If you have questions, call the Help Center at **1-888-466-2219** or **TDD at 1-877-688-9891**. This call is free.

How to File:

1. File online at **www.dmhc.ca.gov** (This is the fastest way).
OR
Fill out and sign the Cancellation of Health Care Coverage Grievance Form.
2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:
Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Fax: 916-255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

This Notice is Required by Law

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call **916-322-6727**.