Member Grievance/Complaint Form

Date:_____ **Please print all information.**

Complainant information:

Name	( ) Work Phone Number	( ) Home Phone Number
Address	City	State Zip Code

Name of person(s) related to complainant:

Name	# ID Number
Name	# ID Number
Name	# ID Number

Nature of complaint: (Check appropriate box(es))

_____ Marketing _____ Difficulty disenrolling _____ Member billing

_____ Quality _____ Transportation _____ Accessibility to care

_____ Emergency care _____ Staff attitude _____ Authorization

Other: _____

Problem statement: Date of Occurrence: _____ Location: _____

Describe the problem/complaint in detail:

I have received a denial for coverage for treatment, services, or supplies deemed experimental and have an incurable or irreversible condition that has a high probability of causing death within one year or less.

Yes, I am requesting a conference: _____

Use the back of this form if additional space is needed.

_____ _____

Signature of Member Date

(or signature of parent where member is a minor or incapacitated)

If you believe a delay in the decision-making may impose an imminent and serious threat to your health, please contact our Member Services Department toll free at 1-888-893-1569 to request an expedited review. If your case meets the criteria for urgent and requires fast review, it will be resolved within 72 hours.

If you have received a denial for coverage and you have an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider you may request a conference. Upon receiving your request, within 30 calendar days, CalViva Health will provide you the opportunity to attend a conference. The conference is held within 5 business days, if your doctor, after consultation with the CalViva Health Chief Medical Officer or designee, determines that the effectiveness of the proposed treatment, services, alternate treatment, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date. You may contact our Member Services Department toll free at 1-888-893-1569 to request a terminally ill conference. You may also request a conference by checking the statement on the first page of this form and returning the completed complaint form to the address below.

If you should have any further questions or need additional assistance concerning this matter, please contact our Member Services Department toll free at 1-888-893-1569 or TTY 711. When complete, please submit this form to: CalViva Health, Attn: Grievance and Appeals Department C-5, 21281 Burbank Blvd. Woodland Hills, CA 91367. Fax number (877) 831-6019.

If you have already filed an Appeal with CalViva Health and did not receive a Notice of Appeal Resolution (NAR) within 30 days from the date you filed the appeal with CalViva Health (or within 72 hours of your filing an expedited appeal with CalViva Health), you have the right to request a State Hearing from the California Department of Social Services. There is a 120 day deadline from the date you received a Notice of Appeal Resolution (NAR) from CalViva Health for filing a State Hearing. You have the right to be represented by legal counsel, a friend, or other spokesperson at the hearing. If you want to request a State Hearing or need assistance obtaining information on legal service organizations for representation, you may call the California Department of Social Services toll-free number at 1-800-952-5253, TDD 1-800-952-8349. You also have the right to request disenrollment from the health plan, through Health Care Options, by calling (800) 430-4263.

The Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program is available to provide assistance in investigating and resolving any grievances you may have about this health plan. If you wish to use the services of the DHCS to help you with your grievance, you may call the Ombudsman Program toll-free at 1-888-452-8609.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your health plan at **1-888-893-1569** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The

department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Note: Appropriate action will be initiated to resolve your complaint. Within **5 calendar days** of receiving your grievance you will receive a response saying we have your grievance and are working on it. Then, within **30 calendar days** of receiving your grievance (or within 72 hours if this is an urgent issue), you will receive a written response letting you know how your grievance was resolved.

MEDICAL RELEASE / MEMBER AUTHORIZATION

All medical records obtained from providers who may have treated you for the condition which is the subject of this grievance will be held in strict confidence and used solely for the purpose of reviewing your grievance.

I HEREBY AUTHORIZE AND REQUEST THE PROVIDER(S) TO RELEASE ANY AND ALL MEDICAL RECORDS TO CALVIVA HEALTH SUPPORTING MEDICAL NECESSITY FOR:

Signature:_____ **Date:** _____

(If signed by other than member) RELATIONSHIP: _____
(MOTHER, FATHER, GUARDIAN)