GRIEVANCE AND APPEAL FORM - MEDI-CAL

Please complete this form in its entirety and return the completed form and any requested information directly to:

Community Health Group
ATTN: Grievance and Appeals Manager
2420 Fenton Street Suite 100
Chula Vista, CA 91914
Telephone (619) 498-6578
Fax (619) 476-3834

You have the right to name someone else to file a grievance or appeal for you. You must first approve in writing. If you are appealing our decision of a service we denied, you have 60 days to file an appeal. We will notify you of our decision in 30 days after we received your appeal. If you feel that your case needs a fast review and you have strong pain or the chance of loss of life, limb or bodily function you can ask for a fast review. For fast reviews, you will hear back from us within three days. Grievances can be filed at any time in accordance with new federal regulations.

MEMBER INFORMATION

What is your name? _____ SSN: _____
Who received or was seeking the services? _____ SSN: _____
Address: _____ Phone Number: _____
Who was the Primary Care Provider at the time you/family member received or was seeking the services?

GRIEVANCE OR APPEAL INFORMATION / REASON

Date this form is being filed: _____

Is this a request that CHG or a CHG contractor change a decision it has made? YES NO

Does this matter involve a serious threat to health, severe pain, or potential loss of life, limb, or major bodily function? Yes No (If you indicate "Yes," then CHG's Chief Medical Officer or designee will make a decision on of whether it should be handled on an expedited basis.)

FOR CHG USE ONLY

CHG's Chief Medical Officer's response: AGREE: _____ DISAGREE: _____ SIGNATURE AND DATE: _____

REMARKS:_____

_____

What is the reason for the grievance or appeal? (Check all that apply or explain under Other)

	Availability of Service Issues (couldn't get care needed)		Not satisfied with response to a complaint
	Access to Care Issues (waiting time in office, etc.)		Other:
	Service or Authorization for Service was denied		
	Provider Dissatisfaction (didn't like provider / staff, etc.)		

Please briefly describe the situation you want CHG to review _____

_____

How would you like your grievance or appeal resolved? _____

Please attach additional page(s) as necessary

☐ Please check here if you would like CHG's Member Advocate to assist with your appeal.

1. Where did you receive or from whom did you request the services? _____
(Address)

2. When did you receive or request the service? _____

3. Is there anything else we should know about your grievance or appeal?_____

_____ _____
Member Signature Date

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 (**1-800-224-7766**) 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-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If you are dissatisfied with a "medical necessity" decision of CHG, you may request an IMR from the California Department of Managed Health Care. If we sent this form to you and at that time it was clear to CHG that you are potentially eligible for an IMR, we have enclosed an IMR Application Form. In that case, if you choose to request an IMR, please use the enclosed form and return to the Department of Managed Health Care in the enclosed envelope. If an IMR Application Form is not included or attached with this form, and you believe you are eligible for an IMR, please contact us immediately and we will provide an IMR Application Form to you. You may also obtain an IMR application form at the Department of Managed Health Care internet web site: www.dmhc.ca.gov. If you are not sure whether you are eligible for an IMR or want more information, please contact CHG's Member Services Department at **1-800-224-7766**.

Decisions which are eligible for IMR are those where CHG or a CHG contractor decided that the request for care or service was not medically necessary. Requests for benefits beyond those included in the benefits package are not eligible for IMR.

IMR is done by an independent review organization (IRO). An IRO is not connected in any way with CHG, and is under contract with the Department of Managed Health Care. CHG must go along with the IRO's decision and carry out its instructions, as required by the Department of Managed Health Care. You are not responsible for the costs of the IMR.

To be eligible for an IMR, you must request the IMR within 180 days (six months) of the date you were notified of a decision to deny, delay or modify authorization or payment for a health care service. If you do not request the IMR within that time, it cannot be reviewed by the IRO, unless the Department of Managed Health Care requires otherwise.

As a Medi-cal member, you may also call the California Department of Health Services Medi-Cal Managed Care Ombudsman at **1-888-452-8609** or request a fair hearing by the State Department of Social Services by calling **1-800-952-5253**. You may

request a fair hearing without first going through the appeal process, or may request a fair hearing at any time during the appeal process.

Community Health Group materials are available in English, Arabic, Spanish, Tagalog and Vietnamese. Please call 1-800-224-7766. Language assistance services are provided free of charge.

Los materiales de Community Health Group están disponibles en inglés, árabe, español, tagalo y vietnamita. Por favor llame al 1-800-224-7766. Los servicios de asistencia lingüística se proporcionan de forma gratuita.

Materyales Community Health Group ay magagamit sa Ingles, Arabic, Espanyol, Tagalog at Vietnamese. Mangyaring tumawag sa 1-800-224-7766. Ang Serbisyo ng ito ay ibinibigay ng walang bayad.

موارد ال كميونتي هيلث كروب متوفرة في اللغات الانكليزية والعربية والاسبانية والتغالوغ والفيتنامية, الرجاء الأتصال على 1-800-224-7766. خدمات الترجمه تقدم لكم مجانا

Nhóm vật liệu y tế cộng đồng có sẵn trong tiếng Anh, tiếng Ả Rập, tiếng Tây Ban Nha, Tagalog và tiếng Việt. Xin vui lòng gọi 1-800-224-7766. Ngôn ngữ hỗ trợ dịch vụ được cung cấp miễn phí.