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 all that apply]

________ 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 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 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/TDD Number: (800)-431-0964). When complete, please submit this form to: CalViva, Attn: Grievance and Appeals Department C-5, 21281 Burbank Blvd. Woodland Hills, CA 91367. Fax number (877) 831-6019.

At any time during the grievance process, you have the right to request a fair hearing from the California Department of Social Services. There is a 90 day deadline from the date of the grievance for filing a fair 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 fair 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-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.

Note: Appropriate action will be initiated to resolve your complaint. You will receive a response within **30 calendar days** from the date of receipt.

MEDICAL RELEASE

MEMBER: Please provide name and telephone number of any providers who may have treated you for the condition which is the subject of this grievance.

All Medi-cal records obtained will be held in strict confidence and used solely for the purpose of reviewing your grievance.

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

Signature: ______________________________________ **Date:** ____________________________

(If signed by other than member) ____
(MOTHER, FATHER, GUARDIAN)