COMMUNITY CARE
HEALTH

Member Grievance Form

You may use this form to ask for a grievance. Please attach any information you have to support the request. Send the form and any supporting information to: Grievances and Appeals, **PO BOX 45020 Fresno, CA 93718**. Or, you may call the toll-free phone number on your member ID card to ask customer service to fill out the form for you. We will send a response to your grievance within 30 calendar days from the date we receive it.

Member Name:	ID Number (see member ID card):
Group Number (see ID card):	Phone Number(s):
Address:	

If you are not the member, please provide the following information:

Your Name:	Relationship to Member (if applicable):
Your Phone Number(s):	
Your Address:	

Are you the member's authorized representative or legal guardian? ☐ YES ☐ NO

Note: We must have written authorization to allow you to act on the member's behalf if you aren't their authorized representative or legal guardian.

Please explain your grievance. Include, if available, the following information:

- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision that you don't agree with; and
- The specific reason(s) why you don't agree with the decision.

If your plan is regulated by the Department of Managed Health Care, please read the following information. If you don't know if your plan is regulated by the Department of Managed Health Care, please look at your benefits booklet. Customer service can also help you. To reach customer service, call the phone number on your member ID card. If your plan isn't regulated by the Department of Managed Health care, your benefits booklet or customer service can give you information about grievance/appeal rights available to you.

*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 **1-855-343-2247**, or at the TDD line **1-800-735-2929**, 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 number **(888-HMO-2219)** and a TDD line **(877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online. You may also contact the department by writing to the following address: 980 9th Street, Suite 500, Sacramento, CA 95814 or by e-mail at **helpline@dmhc.ca.gov**.*

If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and the proposed treatment is denied because it is considered experimental or investigational, you may have the right to meet with us to discuss your case as part of the grievance process. Should you feel this applies to you and you would like to request a meeting, you may call customer service toll free at **1-855-343-2247**. If you have hearing or speech loss, call 1-**866-735-2929**, our TDD line. This right is in addition to any other dispute resolution options available to you as explained in this notice.

Signature:____ Date: ________________

For Use by Community Care Health only:

Representative Name:	Unit/Location:	Date: