Member Grievance & Appeal Form

Purpose

The purpose of this form is to ask L.A. Care Health Plan to initiate the Grievance or Appeals process.

Instructions

1. You may file an Appeal with L.A. Care Health Plan up to 180 calendar days following the denial notice. Your request will be acknowledged within 5 calendar days of receipt, and resolved within 30 calendar days.
    a. An **Appeal** is when you don't agree with L.A. Care's decision not to cover or change your services
2. You may file a Grievance with L.A. Care Health plan at any time following any incident that subject to your dissatisfaction. Your request will be acknowledged within 5 calendar days of receipt, and resolved within 30 calendar days.
    a. A **Complaint (or Grievance)** is when you have a problem with L.A. Care or a provider, or with the health care or treatment you got from a provider
3. If you feel this request is urgent in nature, please contact Member Services at 1-888-839-9909 or the number on the back of your member ID card.
   Examples of urgent requests may include:
4. An imminent and serious threat to your health, including but not limited to, severe pain and /or potential loss of life, limb, or major bodily function.
5. A concern related to cancellation, rescission or nonrenewal of coverage.
6. Briefly outline the specific details of the problem and identify when the event(s) occurred.
7. Be sure to sign, date and include a L.A. Care Health Plan member ID number as well as date of birth.
8. Send this completed form and, if available, all relevant documents to L.A. Care Health Plan. Please keep copies of all items sent to L.A. Care Health Plan for your records.
9. Examples of relevant documents may include:
    - Statements: Premium billing statement or Provider bills
    - Proof of payment: Receipts, a copy of the front and back of a canceled check, or credit card statement
    - Correspondence: Denial letter, plan notices or enrollee correspondence

Submit

Please submit the finished form by mail, in person, or fax:

By Mail or In Person:
Attention: Appeals & Grievances
L.A. Care Health Plan
1200 W. 7th Street
Los Angeles, CA 90017

By Fax:
Attention: Appeals & Grievances
213-428-5748

If you believe this case is urgent, call L.A. Care Health Plan immediately toll-free at 1-888-839-9909

Member Information		
First name:	Last name:	Middle initial:
Member ID#:	Primary Care Provider:	Birth date: MM/DD/YYYY
Email address: (optional)	Daytime phone number: ( )	Evening phone number: ( )
Home address:		
City:	State:	ZIP code:
Mailing address: (if different from home address)		
City:	State:	ZIP code:
Submitter Information (If submitter is different than member)		
First name:	Last name:	Middle initial:
Relationship to Member:	Daytime phone number: ( )	Evening phone number: ( )
Address:		
City:	State:	ZIP code:

The member can name a relative, friend, advocate, attorney, doctor, or someone else to act for them. The person that acts on their behalf, authorized representative, requires signed permission.

Do you have documented signed permission to act on the Member's behalf? O Yes O No

If Yes, please attach a copy of the document(s).
If No, please continue with completing the grievance form and L.A. Care will contact you to help with the next steps.

Description of Concern	
Involved Doctor or Provider full name:	Doctor/Provider Phone number: ( )
Where did the problem occur? (Name of Pharmacy, Hospital, Medical Office, etc.)	Date of Incident: MM/DD/YYYY / /

Who was involved beside yourself? (Give names of involved staff, if possible)
Briefly outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. Please include a statement regarding the outcome desired and what you believe the Plan can do to resolve your concern. If you have copies of documents, bills, checks, or other correspondence related to this problem that may help in the investigation and resolution, please include them with this form. If this involves a denial, please include the denial reference number. If you need more pages to describe the issue, please attach them to this form.

Date member received notice that coverage was or will end: (if applicable) / /	Are copies of member correspondence attached? (if applicable) O Yes O No

Signature		
Member name:	Member signature:	Date: MM/DD/ YYYY
Submitter name:	Submitter signature:	Date: MM/DD/YYYY

Members Rights

Department of Managed Health Care

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 **1-888-839-9909** 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 http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.
If you have any other questions or concern(s) on this matter, please call L.A. Care at **1-888-839-9909**.

Medicare Members

You can contact this program with questions about your Medicare benefits at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
(You can also read or download
"Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

California Department of Health Care Services (DHCS) Office of the Ombudsman

You may also call the Ombudsman Office of the California Department of Health Care Services (DHCS) for help. The Ombudsman Office helps Medi-Cal beneficiaries to fully use their rights and responsibilities as a member of a managed care plan. To find out more, call toll-free **1-888-452-8609** Monday through Friday, 8am to 5pm PST; excluding holidays.

Additional Rights for Medi-Cal Members

State Hearing

You may ask for a State Hearing within 120 days of receiving the Notice of Appeal Resolution from L.A. Care. You may either present your case yourself, or ask someone to present your case, such as legal counsel, relative, friend, or any other person. For more about State Hearing requests, please call **1-800-952-5253** Monday through Friday, 8:00 a.m. to 5:00 p.m.; excluding holidays. For the hearing impaired TDD, please call **1-800-952-8349**.
To request a State Hearing in writing please send your letter to the following address:
California Department of Social Services
State Hearing Division
P. O. Box 944243, MS 9-17-433
Sacramento, CA 94244-2430

You have the right to submit a grievance, pursuant to L.A. Care's standard grievance procedures, for failure of plan staff to provide trans-inclusive care.

If you need assistance, we're here to help. You can call L.A. Care Member Services at **1-888-839-9909**. We are available to assist you 24 hours a day 7 days a week including holidays.