Member Grievance Form

Member Name:
____
Last First Middle Initial

Member Address: ___________________________ Phone: _________________________

City: _____________________________ State: ___________ Zip Code: ______________________

Member ID#:________________________ Birthdate:_______________ Sex: ___________________

Primary Care Provider Name:
____

Complaint

Where did the problem happen? (Name of hospital, doctor office or other location)
____
____

When did this happen? (Include date)
____
____

Who was involved?
____
____

Please describe what happened: (Attach additional pages, if necessary)
____
____

Have you made an attempt to resolve this problem? Yes No If you answered “yes”, please explain:
____
____

What would you like to see done about this problem?
____
____

Will you require language assistance? Yes No Language: ______________________________

Member Grievance Form

Do you have any physical or other limitations that would prevent you from attending a grievance meeting? Yes No If you answered "yes", please explain:

____

____

____

____.

I know and understand that Health Plan of San Joaquin will resolve my grievance within 30 days.

I know and understand that my assistance is voluntary. However, failure to do so could affect my grievance.

I know and understand that I have a right to:

- Disenrollment;
- Contact the Department of Managed Health Care (DMHC);
- File a State Fair Hearing (Medi-Cal members only).

____ ______________________________

Signature Date

I approve Health Plan of San Joaquin to get the following in order to resolve a grievance on my behalf:

- Medical records;
- Claims records;
- Other data needed to resolve my grievance.

____ ______________________________

Signature Date

Did someone help you complete this form? Yes ☐ No ☐ if you answered "Yes":

Name: ____ Relationship: ________________

Address: ______________________________________ Telephone: __________________

Signature: _____________________________________ Date: ______________________

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

If you still do not agree with this decision, you can:

- Ask for an **"Independent Medical Review" (IMR)** and an outside reviewer that is not related to the health plan will review your case
- Ask for a **"State Hearing"** and a judge will review your case

You can ask for an IMR and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first. For example, if you ask for an IMR first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, but the hearing has already taken place, you cannot ask for an IMR.

You will not have to pay for an IMR or State Hearing.

INDEPENDENT MEDICAL REVIEW (IMR)

The following paragraph will provide you with information on how to request an IMR. In this paragraph, the term "grievance" means the same thing as "appeal."

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 **209- 942-6320** 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 an 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 Website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms, and instructions online.

STATE HEARING

If you want a State Hearing, you must ask for one within **120 days** from the date of this letter. However, **if you are currently getting treatment and you want to continue to keep your treatment going, you must ask for a State Hearing within 10 days** from the date this letter was postmarked or delivered to you, or before the date your health plan says services will be stopped or reduced. Please state that you want to keep getting your treatment going when you ask for the State Fair Hearing.

You can ask for a State Hearing over the phone or in writing:

- If you decide to ask for a State Hearing by phone, please call **1-800-952-5253**. This number can be very busy, so you may get a message to call back later. If you have trouble speaking or hearing, please call **TTY/TDD 1-800-952-8349**.

- If you decide to ask for a State Hearing in writing, you will need to fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  A State Hearing form is enclosed for you. Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak, and we will provide one for free.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will harm your health, you might be able to get an answer within 72 hours. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously jeopardize your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an **"expedited hearing,"** and provide the letter with your request for a hearing.

LEGAL HELP

You may speak for yourself at the State Hearing or have another person speak for you, such as a relative, friend, advocate, doctor, or attorney. If you want another person to speak for you, then you must ask the other person yourself. You may be able to get free legal help. Call the Consumer Complaint and Protection Coordinators at **1-800-952-5210**. You may also call the local Legal Aid Society in your county at **1-888-804-3536**.

NONDISCRIMINATION STATEMENT

Health Plan of San Joaquin complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Plan of San Joaquin does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Plan of San Joaquin:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Customer Service Department **888.936.PLAN (7526), (TTY/TDD) 711**

HOW TO FILE A GRIEVANCE

If you believe that Health Plan of San Joaquin has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Health Plan of San Joaquin
Attn: Grievance Coordinator
7751 S. Manthey Rd.
French Camp, CA 95231

You can also call our toll free number by calling **888.936.PLAN (7526)**, **(TTY/TDD) 711**, or fax it to **209.461.2550 –** Attn: Grievances. You can file a grievance in person or fill out our online form, fax, or email. If you need help filing a grievance, HPSJ's Grievance Department is available to help you.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Health Plan of San Joaquin

Get help in your language

LANGUAGE ASSISTANCE SERVICES

English
ATTENTION: If you speak another language, free language assistance services are available to you. Call 1-888-936-(PLAN)7526 (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-936-(PLAN)7526 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-936-(PLAN)7526 (TTY: 711).

Tagalog (Tagalog–Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-936-(PLAN)7526 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-936-(PLAN)7526 (TTY: 711)번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 [1-888-936-(PLAN)7526 (TTY: 711)。

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Հայ_ ե ր ե ն _ (Armenian)
ՈՒՇԱԴՐՈՒԹՅ ՈՒՆ՝ Եթե խո ս ո ւ մ եք հայ ե ր ե ն , ապա ձե զ ա ն վ ճ ար կար ո ղ են տր ամ ադ ր վ ե լ լե զ վ ակ ան աջ ակ ց ութ յան ծառայություններ: Զանգահարեք 1-888-936-(PLAN)7526 (TTY (հեռատիպ)՝ 711):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-936-(PLAN)7526 (телетайп: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان **(Farsi)**فارسی
برای شما فراهم می باشد. با(1-888-936-(PLAN)7526 (TTY: 711 تماس بگیرید.

日本語**(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-936-(PLAN)7526 (TTY: 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-936-(PLAN)7526 (TTY:711).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-936-(PLAN)7526 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية(Arabic)

ملحوظة : إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل1-888-936-(PLAN)7526 برقم711 رقم هاتف الصم والبكم

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।1-888-936-(PLAN)7526 (TTY: 711) पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-936-(PLAN)7526 (TTY: 711).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-936-(PLAN)7526 (TTY: 711)។