

Member Appeal Form

Member Name: _____
Last First Middle Initial
Member Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Member ID#: _____ Birthdate: _____ Sex: _____
Doctor's Name: _____

Appeal

What do you want to appeal? (List item/service/med that is denied/deferred/modified) _____

When was this denied? (List date denied. This can be the date on your NOA letter) _____

Why is this being appealed? (List why this is medically necessary for you) _____

Please list any records are sending in with this form: (Such as: a copy of your doctor's notes or an x-ray) _____

Have you tried any other things (Meds/Treatments)? Yes ☐ No ☐ If you said "yes", please explain: _____

Will you need language help? Yes ☐ No ☐ Language: _____

Your Rights:

Health Plan of San Joaquin will send me an appeal resolution within 30 days of getting this appeal.

My cooperation is voluntary.

I have the right to disenrollment.

I have the right to contact the Department of Managed Health Care.

I have the right to a State Fair Hearing (Medi-Cal members only).

Signature Date

I allow Health Plan of San Joaquin to get: medical records; claims records; or other records.
These records will be used for my appeal.

Signature Date

Do you want your doctor to file an appeal for you? Yes ☐ No ☐ If you answered
"Yes": I Allow my doctor _____ (List Doctor's name) to file an
appeal on my behalf.

Signature Date

Did someone help you fill out 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)

If you want an IMR, you must ask for one within **180 days** from the date of the "Notice of Appeal Resolution" letter. 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website (<http://www.dmhca.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 **1-800-743-8525**. 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 **209.942.6355** – Attn: Grievances. You can file a grievance in person or fill out our online form [<https://www.hpsj.com/member-grievance-form/#top>], 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>.

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)]。

Հայերեն (Armenian)

ՈՒՇԱՐԴՈՒԹՅՈՒՆ Եթե խոսում եք հայերեն, ապաձեզ անվճար կարող են տրամադրվել լեզվականաջակցություններ: Ձանգահարեք 1-888-936-(PLAN)7526 (TTY (հեռախոս)՝ 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 بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان **(Farsi)** فارسی برای شما فراهم می باشد. با (1-888-936-888 (TTY: 711) (PLAN)7526 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 ਤੁਸੀਂ ਪੰਜਾਬੀ 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. اتصل 1-888-936-(PLAN)7526
رقم هاتف الصم والبكم 711 برقم

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, បសវន៍នួយខ្លួនកភាសា បោយមិនគិតល គឺអាចមានសំរាប់បរិស្ថាន។ ចូរ ទូរស័ព្ទ 1-888-936-(PLAN)7526 (TTY: 711)។

Additional SFH Rights Addendum

Temporary Emergency State Fair Hearing Extended Filing Timeframes

Changes to the time frames: Before the COVID-19 Crisis, members had 120 days (4 months) from the date of their NAR letter to file a SFH. Members will now have 240 days (8 months) from the date of their NAR letter to file a SFH starting March 1, 2020 through the end of the COVID-19 Crisis.