Health Plan of San Joaquin

# 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.dmhc.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.

Health Plan of San Joaquin

# Nondiscrimination Notice

Discrimination is against the law. Health Plan of San Joaquin follows State and Federal civil rights laws. Health Plan of San Joaquin does not unlawfully discriminate, exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Health Plan of San Joaquin provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats and other formats)
- 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 Health Plan of San Joaquin between Monday-Friday 8:00 a.m. - 5:00 p.m. by calling 888.936.7526. If you cannot hear or speak well, please call TTY/TDD 711 to use the California Relay Service. Upon request, this document can be made available to you in braille, large print, audio, and accessible electronic format. To obtain a copy in one of these alternative formats, please call or write to:

**Health Plan of San Joaquin**
**7751 South Manthey Road, French Camp, CA 95231**
**888.936.PLAN (7526), TTY/TDD 711**

## HOW TO FILE A GREVIANCE

If you believe that Health Plan of San Joaquin has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with Health Plan of San Joaquin's Civil Rights Coordinator, the Chief Compliance Officer. You can file a grievance in writing, in person, or electronically:

- By phone: Contact between Monday - Friday, 8:00 a.m. - 5:00 p.m. by calling 888.936.7526. Or, if you cannot hear or speak well, please call TTY/TDD 711.
- In writing: Fill out a complaint form or write a letter and send it to: Health Plan of San Joaquin
  **Attn: Grievance and Appeals Department**
  **7551 S. Manthey Road**
  **French Camp, CA 95231**

Call customer service toll free at 888.936.PLAN (7526) TTY/TDD 711.
Health Plan of San Joaquin is open Monday -Friday, 8:00 a.m. - 5:00 p.m.
Visit online at www.hpsj.com

**888.936.PLAN (7526), TTY/TDD 711**
By fax: 209.942.6355

- In person: Visit your doctor's office or Health Plan of San Joaquin and say you want to file a grievance.
- Electronically: Visit Health Plan of San Joaquin's website at www.hpsj.com

If you need help filing a grievance, a Customer Service Representative can help you.

## OFFICE OF CIVIL RIGHTS - CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916.440.7370**. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:
  **Deputy Director, Office of Civil Rights**
  **Department of Health Care Services Office of Civil Rights**
  **P.O. Box 997413, MS 0009**
  **Sacramento, CA 95899-7413**

  Complaint forms are available at http:www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov

## OFFICE OF CIVIL RIGHTS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the bases of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights by phone, in writing, by phone or electronically:

- By phone: Call **1.800.368.1019**. If you cannot speak or hear well, please call **TTY/TDD 1.800.537.7697**.
- In writing: Fill out a complaint form or send a letter to:
  **U.S. Department of Health and Human Services**
  **200 Independence Avenue, SW**
  **Room 509F, HHH Building**
  **Washington, D.C. 20201**

  Complaint forms are available at http:www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Call customer service toll free at 888.936.PLAN (7526) TTY/TDD 711.
Health Plan of San Joaquin is open Monday -Friday, 8:00 a.m. - 5:00 p.m.
Visit online at www.hpsj.com

Health Plan of San Joaquin

**Language Assistance**

**English Tagline**
ATTENTION: If you need help in your language call **888.936.7526, TTY/TDD 711**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **888.936.7526, TTY/TDD 711**. These services are free of charge.

**الشعار بالعربية (Arabic)**
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **888.936.7526, TTY/TDD 711**. تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **888.936.7526, TTY/TDD 711**. هذه الخدمات مجانية.

**Հայերեն պիտակ (Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **888.936.7526, TTY/TDD 711**: Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **888.936.7526, TTY/TDD 711**: Այդ ծառայություններն անվճար են:

**ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)**
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **888.936.7526, TTY/TDD 711**។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុសសម្រាប់ជនពិការ ភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **888.936.7526, TTY/TDD 711**។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

**简体中文标语 (Chinese)**
请注意：如果您需要以您的母语提供帮助，请致电 **888.936.7526, TTY/TDD 711**。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **888.936.7526, TTY/TDD 711**。这些服务都是免费的。

**مطلب به زبان فارسی (Farsi)**
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **888.936.7526, TTY/TDD 711** تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **888.936.7526, TTY/TDD 711** تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

**हिंदी टैगलाइन (Hindi)**
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **888.936.7526, TTY/TDD 711** पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **888.936.7526, TTY/TDD 711** पर कॉल करें। ये सेवाएं निः शुल्क हैं।

**Nqe Lus Hmoob Cob (Hmong)**
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **888.936.7526, TTY/TDD 711**. Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **888.936.7526, TTY/TDD 711**. Cov kev pab cuam no yog pab dawb xwb.

**日本語表記 (Japanese)**
注意日本語での対応が必要な場合は **888.936.7526, TTY/TDD 711**へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。**888.936.7526, TTY/TDD 711**へお電話ください。これらのサービスは無料で提供しています。

**한국어 태그라인 (Korean)**
유의사항: 귀하의 언어로 도움을 받고 싶으시면 **888.936.7526, TTY/TDD 711** 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **888.936.7526, TTY/TDD 711** 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

**ແທກໄລພາສາລາວ (Laotian)**
ປະກາດ:
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **888.936.7526, TTY/TDD 711**.
ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **888.936.7526, TTY/TDD 711**.
ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

**Mien Tagline (Mien)**
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **888.936.7526, TTY/TDD 711**. Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **888.936.7526, TTY/TDD 711**. Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

**ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)**
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **888.936.7526, TTY/TDD 711**.
ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ **888.936.7526, TTY/TDD 711**.
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

**Русский слоган (Russian)**
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **888.936.7256 (линия TTY/TDD711)**. Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **888.936.7256 (линия TTY/TDD 711)**. Такие услуги предоставляются бесплатно.

**Mensaje en español (Spanish)**
ATENCIÓN: si necesita ayuda en su idioma, llame al **888.936.7526, TTY/TDD 711**. También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **888.936.7526, TTY/TDD 711**. Estos servicios son gratuitos.

**Tagalog Tagline (Tagalog)**
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **888.936.7526, TTY/TDD 711**. Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **888.936.7526, TTY/TDD 711**. Libre ang mga serbisyong ito.

**แท็กไลน์ภาษาไทย (Thai)**
**โปรดทราบ:**
**หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 888.936.7526, TTY/TDD 711 นอกจากนี้**
**ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 888.936.7526, TTY/TDD 711 ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้**

**Примітка українською (Ukrainian)**
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **888.936.7526, TTY/TDD 711**. Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **888.936.7526, TTY/TDD 711**. Ці послуги безкоштовні.

**Khẩu hiêu tiếng Viêt (Vietnamese)**
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **888.936.7526, TTY/TDD 711**. Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **888.936.7526, TTY/TDD 711**. Các dịch vụ này đều miễn phí.