Health Plan of San Joaquin

Mountain Valley Health Plan

Member Grievance Form

Member Name _____ _____ _____
Last First Middle Initial

Member Address _____ Phone _____

City _____ State _____ Zip Code _____

Member ID# _____ Birth Date _____ 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: _____

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/Mountain Valley Health Plan ("Health Plan") 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 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 _____ Phone _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

Health Plan of San Joaquin

Mountain Valley Health Plan

YOUR RIGHTS UNDER MEDI-CAL MANAGED CARE

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

- Ask for an Independent Medical Review and an outside reviewer that is not related to your health plan will review your case.
- Ask for a State Hearing and a judge will review your case.

You can ask for both an Independent Medical Review 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 Independent Medical Review 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, and the State Hearing has already taken place, then you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or State Hearing.

INDEPENDENT MEDICAL REVIEW

If you want an Independent Medical Review, you must ask for one within 180 days from the date of this Notice of Appeal Resolution letter. The paragraph below provides you with information on how to request an Independent Medical Review.[1] Note that the term “grievance” is talking about both “complaints” and “appeals.”

“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.”

[1] Health and Safety Code (HSC) section 1368.02(b). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/home.xhtml.

STATE HEARING

If you want a State Hearing, you must ask for one within 120 days from the date of this Notice of Appeal Resolution letter. However, if your health plan continued to provide you with the disputed service(s) (Aid Paid Pending) during the health plan's appeal process and you want the service(s) to continue until there is a decision on your State Hearing, you must request a State Hearing within 10 days of this Notice of Appeal Resolution letter. Even though your health plan must give you Aid Paid Pending when you ask for a State Hearing in this way, you should let your health plan know you want to get Aid Paid Pending until your State Hearing is decided. You should contact Health Plan of San Joaquin/Mountain Valley Health Plan between 8 a.m. - 5 p.m. by calling **1-888-936-PLAN (7526)**. If you cannot hear or speak well, please call **711** (TTY).

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov

- By phone: Call **1-800-743-8525**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD **1-800-952-8349**.

- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

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

  Fax: **916-309-3487** or toll-free at **1-833-281-0903**

  A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN 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 the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

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 hurt your health, you might be able to get an answer within 3 days. 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 harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an Expedited Hearing and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearings Division that the person is allowed to speak for you. This person is called an Authorized Representative.

LEGAL HELP

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 Notice

Discrimination is against the law. Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") follows State and Federal civil rights laws. Health Plan 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 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 between Monday-Friday 8:00 a.m. - 5:00 p.m. by calling **1-888-936-7526**. If you cannot hear or speak well, please call TTY 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/Mountain Valley Health Plan
7751 South Manthey Road, French Camp, CA 95231
1-888-936-PLAN (7526), TTY 711

HOW TO FILE A GRIEVANCE

If you believe that Health Plan 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'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 **1-888-936-7526**. Or, if you cannot hear or speak well, please call TTY 711.
- In writing: Fill out a complaint form or write a letter and send it to:

  Health Plan of San Joaquin/Mountain Valley Health Plan
  Attn: Grievance and Appeals Department
  7751 S. Manthey Road, French Camp, CA 95231

  By fax: 209-942-6355

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

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 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 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 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.

Language Assistance

English Tagline

ATTENTION: If you need help in your language call **1-888-936-7526, TTY 711**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-888-936-7526, TTY 711**. These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1-888-936-7526, TTY 711.** تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1-888-936-7526, TTY 711**. هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-888-936-7526, TTY 711**: Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-888-936-7526, TTY 711**: Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1-888-936-7526, TTY 711**។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុសសម្រាប់ជនពិការ ភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-888-936-7526, TTY 711**។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)

请注意：**如果您需要以您的母**语提供帮助，请致电 **1-888-936-7526 (TTY: 711)**。**我**们另外还提供针对残疾人士的帮助和服务，**例如盲文和大字 体**阅读，**提供您方便取用**。请致电 **1-888-936-7526 (TTY: 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 **1-888-936-7526, TTY 711** تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-888-936-7526, TTY 711** تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-888-936-7526, TTY 711** पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-888-936-7526, TTY 711** पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-888-936-7526, TTY 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 **1-888-936-7526, TTY 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 **1-888-936-7526, TTY 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。**1-888-936-7526, TTY 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 **1-888-936-7526, TTY 711** 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-888-936-7526, TTY 711** 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ:
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃ
ຫ້ໂທຫາເບີ **1-888-936-7526, TTY 711**.
ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່
ໃຫ້ໂທຫາເບີ **1-888-936-7526, TTY 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 **1-888-936-7526, TTY 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 **1-888-936-7526, TTY 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 **1-888-936-7526, TTY 711**. ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1-888-936-7526, TTY 711**. ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-888-936-7526 (линия TTY 711)**. Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-888-936-7526 (линия TTY 711)**. Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-888-936-7526, TTY 711**. También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-888-936-7526, TTY 711**. Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-888-936-7526, TTY 711**. Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-888-936-7526, TTY 711**. Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ:
หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-936-7526, TTY 711 นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-936-7526, TTY 711 ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-888-936-7526, TTY 711**. Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-888-936-7526, TTY 711**. Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-888-936-7526, TTY 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 **1-888-936-7526, TTY 711**. Các dịch vụ này đều miễn phí.