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?

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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 _____