Health Plan of San Joaquin
Mountain Valley Health Plan

Member Appeal Form

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 **1-888-936-7526 (TTY 711)** 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 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 **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

In accordance with Health and Safety Code section 1367.043 and guidance from the Department of Managed Health Care and the Department of Health Care Services, Health Plan has updated its grievance form to better reflect your rights. You have the right to file a grievance if you feel you were not treated in a way that affirms your gender identity by Health Plan staff or providers, or if you were denied medically necessary, gender-affirming or trans-inclusive care. Health Plan is committed to providing respectful, inclusive, and equitable care to all members. Your voice matters, and we encourage you to share your concerns so we can continue to improve the care and services we provide.

Health Plan of San Joaquin | Mountain Valley Health Plan

Member Appeal Form

Member Name _____ _____ _____
Last First Middle Initial

Member Address _____ Phone _____

City _____ State _____ Zip Code _____

Member ID# _____ Birth Date _____ Sex _____

Primary Care Provider 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 require language assistance? ☐ Yes ☐ No

Language: _____

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Member Appeal Form

Your Rights

Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") 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 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 complete this form? ☐ Yes ☐ No
If you answered "Yes":

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

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 **(1-888-936-7526)** 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 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 **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

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[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. and 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:

  Mail: California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-433
  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**.