Health Plan of San Joaquin | Mountain Valley Health Plan

Member Grievance 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.

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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 _____