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SECTION: Office Management	
POLICY AND PROCEDURE: Member Grievances/Complaints	Approved date: _____ Approved by: _____ Effective date: _____ Revised date: _____ Revised date: _____

POLICY:

The site has an established process for member grievances and complaints.

- A “grievance” is defined as any written or oral expression of dissatisfaction that involves coverage dispute, healthcare medical necessity, experimental or investigational treatment. The health plan does not delegate the resolution of grievances to contracted medical groups.
- A “complaint” is any expression of dissatisfaction regarding the quality of service (excluding quality of care) which can be resolved in the initial contact. A “complaint” is self limiting (e.g. service complaints, appointment wait times) that can be resolved to the member’s satisfaction, such as they do not ask for additional assistance

PROCEDURE:

A. The staff will ensure that any member who expresses a grievance or complaint is informed of the right for a State Fair Hearing and offered the following numbers:

1. The California Department of Managed Health Care 1-888-466-2219
2. For Hearing and Speech impaired call 1-800-735-2929
3. State Fair Hearing 1-800-952-5253

B. Staff will ensure that grievance forms **(in threshold languages) for each participating health plan** will be provided to members promptly upon request.

- The grievance form must be submitted to the health plan **within 1 business day.**

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C. The staff will ensure that all complaints (self limiting complaints: e.g. service complaints, appointment wait times) are logged and submitted to the health plan monthly (if there were complaints during the time period).

1. These complaints may be resolved at the point of service
2. Log the complaint and include:
 - a. Date of complaint
 - b. Name of complainant and ID#
 - c. Nature of the complaint
 - d. Resolution/action taken (include information that health plan was notified as appropriate)
 - e. Date of resolution/action
 - f. Date log submitted to health plan