State of California

Health and Human Services Agency

Department of Managed Health Care

GRIEVANCE/COMPLAINT FORM

DMHC 61-233 (8/17)

To: Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 1-888-466-2219
TDD: 1-877-688-9891
Fax: 1-916-255-5241
www.healthhelp.ca.gov

Date: _____

CANCELLATION OF HEALTH CARE COVERAGE GRIEVANCE FORM

I request that the Director of the Department of Managed Health Care (DMHC) review the cancellation, rescission, and/or nonrenewal of the plan enrollment, subscription, or contract for health care coverage, as follows:

1. Full name of enrollee, subscriber, or group contract holder whose health care coverage was canceled, rescinded, or not renewed:

_____

2. Full name of subscriber, if different than "1" above:

_____

3. Date of Birth (mm/dd/yyyy):

_____

4. Gender:

_____

5. Mailing address (including city, state, and zip code) of enrollee, subscriber, or group contract holder listed above:

_____

6. Daytime and evening telephone numbers of enrollee, subscriber, or group contract holder listed above:

_____

7. Email Address (if available):

_____

8. Name of health plan:

9. Subscriber or Enrollee Member Number:

10. Medical Group Identification Number, if applicable:

11. Employer, if applicable:

12. Medi-Cal identification number, if applicable:

13. Medicare or Medicare Advantage identification number, if applicable:

14. State the date (if known) when you received a notice from your health plan that your health care coverage will be or has been canceled, rescinded, or not renewed:

Date of Notice: _____
mm/dd/yyyy

Date of Receipt (if known): _____
mm/dd/yyyy

15. Attach copies of:

(a) Any notices sent by the plan about the cancellation, rescission, or nonrenewal.

(b) Any letters or email with the plan about the cancellation, rescission, or nonrenewal.

(c) Proof of payment for the last paid coverage period and date of payment.

16. State why you believe the cancellation, rescission, or nonrenewal is wrong, and attach copies of any documents that explain or support your position.

17. Does the cancellation, rescission, or nonrenewal prevent you or any enrollee covered under the health plan from getting medically necessary care or treatment? If "yes," please explain including whether the care or treatment is urgently needed.

❑ Yes ❑ No

18. Briefly describe any other problem you are having with your health plan. For example, please explain if the problem is an unpaid claim, lack of access to care when your coverage was canceled, quality of service from your health plan, or quality of care from a provider.

19. If you filed a grievance or appeal with Covered California or another state agency such as a Medi-Cal State Fair Hearing, please provide your reference number and attach copies of any related documents (if available).

VOLUNTARY STATISTICAL INFORMATION

You are asked to voluntarily provide the following information. Giving this information will help the Department of Managed Health Care to identify any pattern of problems. Giving this information is voluntary and will not affect the decision on your grievance.

Primary Language Spoken: _____

Race/Ethnicity: _____

Gender: [_] Male [_] Female [_] Other _____

Enrollee, Legal Guardian, or Parent Signature: _____

Date: _____

MEDICAL RELEASE

I request the Department of Managed Health Care to make a decision about my problem with my plan. I request the DMHC to review my Cancellation of Health Coverage Grievance Form to determine if my grievance qualifies for the DMHC's Consumer Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my grievance. These records may also include non-medical records and any other information related to my grievance. I allow the DMHC to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Enrollee, Legal Guardian, or Parent Signature: _____

Date: _____

Please see the instruction sheet for mailing or faxing information.

AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your grievance, complete Parts A and B below.

If you are a parent or legal guardian submitting this grievance for a child under the age of 18, you do not need to complete this form.

If you are filing this grievance for an enrollee who cannot complete this form because the enrollee is either incompetent or incapacitated, and you have legal authority to act for this enrollee, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the enrollee.

PART A: ENROLLEE

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my grievance will be shared.

My approval of this assistance is voluntary, and I have the right to end it. If I want to end it, I must do so in writing.

Enrollee Signature: _____ Date: _____

PART B: PERSON ASSISTING ENROLLEE

Name of Person Assisting (print):

_____

Signature of Person Assisting:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Enrollee: _____

Daytime Phone Number: _____ Evening Phone Number: _____

Email Address (if available): _____

My power of attorney for health care decisions or other legal document is attached: _____ (check if applicable)

GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

How to File:

1. File online at www.healthhelp.ca.gov. [This is the fastest way.]

   OR

   Fill out and sign the Cancellation of Health Care Coverage Grievance Form.

2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:

   Department of Managed Health Care

   Help Center

   980 9th Street, Suite 500

   Sacramento, CA 95814-2725

   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code Section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.