Member Grievance Form

You can use this form to file a grievance. Please attach any information you have to explain what happened. Send the form and any supporting information to: **Community Care Health, Attention Grievances and Appeals, PO BOX 45026, Fresno, CA 93718**.

You can also call 1-855-343-2247 to ask Customer Service to fill out the form for you. We will send a letter acknowledging your grievance within five calendar days from the date we receive it. We will also send a response to your grievance within 30 calendar days from the date we receive it.

Member Name:	ID Number (see member ID card):
Group Number (see ID card):	Phone Number(s):
Address:	

If you are not the member, please provide the following information:

Your Name:	Relationship to Member (if applicable):
Your Phone Number(s):	Phone Number(s):
Address:	
Are you the member's authorized representative or legal guardian? ☐ YES ☐ NO ***Note:*** We must have written authorization to allow you to act on the member's behalf if you aren't their authorized representative or legal guardian. **Please explain your grievance. Include, if available, the following information:**	
• The name of the provider who will or has provided care;	
• The date(s) of service;	
• The claim or reference number;	
• And the specific reason(s) why you are unhappy or don't agree with the decision.	

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 **1-855-343-2247** or TDD line **1-800-735-2929** 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.

If you have a terminal illness and the proposed treatment is denied because it is considered experimental or investigational, you may have the right to meet with us to discuss your case as part of the grievance process. Should you feel this applies to you and you would like to request a meeting, please contact Customer Service toll free at **1-855-343-2247** or **1-800-735-2929** for the hearing and speech impaired. This right is in addition to any other dispute resolution options available to you as explained in this notice.

You also have the right to file a grievance if you believe that Community Care Health failed to provide trans-inclusive health care. "Trans-inclusive health care" means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse or intersex (TGI), honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

Signature: _____ Date: _____

For Use by Community Care Health only:		
Representative Name:	Unit/Location:	Date: