Grievance Form for California HMO Members

Attention Medicare + Choice members – do not complete this form. Request the "California Medicare + Choice Plan Member Appeal and Grievance Form"

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

You have the right to file a grievance about any of your medical care or service. If you want to file a grievance, please use this form. There is a process you need to follow to file a grievance. Your health plan must, by law, give you an answer within 30 days. If you have any questions, please feel free to call your doctor's office or health plan at the phone numbers on the back of this form. You may also call the phone numbers on your health identification (ID) card. If you think that waiting for an answer from your health plan will hurt your health, call and ask for an "Expedited Review."

Please print or type the following information:

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Member Name (Last, first, middle initial)

______________________ ______________________
Address | Home Phone number (include area code)

______________________ ______________________
City, State, Zip | Work Phone number (include area code)

______________________ ______________________
Name of Employer or Group | Enrollment or Member ID #

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Date of Birth

If someone other than the member is filing this grievance, please provide the following information:

Name: ______________________ Daytime Telephone # ______________________

Relationship to Member: ______________________________

Address: ______________________________________

City: ______________________ State: __________ Zip: ______________________

Do you have a Terminal Illness? ☐ YES ☐ NO

Is the treatment Experimental or Investigational? ☐ YES ☐ NO

Write what your grievance is about. Give dates, times, people's names, places, etc. that are involved. If you need more room, please attach another piece of paper.

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Please attach copies of anything that may help us understand your grievance.

☐ If you attach other pages, please check this box.

Please sign and MAIL or FAX, if applicable, TO
Aetna Health of California Inc.
Attn: Commercial Grievance & Appeals
P.O. Box 24030
Fresno, CA. 93779
Standard Fax: 860-262-7705
Member Services: 800-445-5299
TDD-TTY: (800) 628-3323
Fax 860-754-5321 (72 Hr. Expedited)

Date___________ **Member Signature**: ____

Date __________ **Signature of Representative** ___________________________________

NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE:

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 **1-800-445-5299** 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 treatment 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 Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.