

Member Grievance Form

You may file a grievance in one of the following ways:

- Call the Member Services phone number on your MemorialCare Select Health Plan ID card.
- Submit your grievance online by logging into the member portal and filling out this form. You can attach documents too.
- Mail this completed form with any attachments. Please, write neatly.
- Mail to: **MemorialCare Select Health Plan, Attn:
Complaints and Grievance
17360 Brookhurst Street Fountain Valley, CA 92708**

Information you provide us becomes part of the permanent grievance record. You will be sent an acknowledgment within 5 calendar days and a response within 30 calendar days of us receiving this form or your call.

Tell us about you:

Date: _____

Member Name: _____ Member ID # /CIN #: _____

Address: _____

City: _____, CA ZIP _____

Phone Number: _____

Tell us about your grievance:

Date of Incident: _____

Describe What Happened (Attach additional pages, if necessary):

Signature of Member (parent or guardian if the member is a minor.)

X _____ Date: _____

HOW TO FILE A GRIEVANCE

MemorialCare Select Health Plan has a formal process for reviewing member grievances and appeals. This process provides a uniform and equitable treatment of your grievance/appeal and a prompt response.

MemorialCare Select Health Plan shall ensure that all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with visual or other communicative impairment. Such assistance shall include, but not be limited to, translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Definition of a Grievance

A grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a member or the member's representative. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Members have up to 180 calendar days from the date of an incident or dispute, or from the date the member receives a denial letter, to submit a grievance or appeal to MemorialCare Select Health Plan.

Standard Grievance/Appeal

Review Steps in the process

1. File your grievance or appeal with MemorialCare Select Health Plan. You may also authorize someone to represent you. Authorization must be in writing. Call Member Services for the authorization form. Your Member Services number is on the back of your membership card.

You can file your grievance by:

- a. Calling Member Services. Your Member Services number is on the back your membership card.
- b. Mailing a letter or a completed grievance form which you can get on the website or by calling Member Services
- c. Submitting a grievance form online.

2. We will send you an acknowledgement letter within five (5) calendar days of receipt.
3. We will fully investigate your grievance/appeal, including all aspects of medical care involved. All medical records and/or responses that will assist with review of your case are requested. Clinical grievances/appeals are reviewed by staff medical personnel and physician specialists. Non-medical grievances are reviewed by grievance specialists. We will provide a written response to you within 30 calendar days after we receive your grievance/appeal.

Expedited Review

The grievance system includes an expedited review process for urgent grievances and appeals. A grievance/appeal is expedited when a delay in decision-making may seriously jeopardize the life or health of a member or their ability to regain maximum function. This includes but is not limited to severe pain, potential loss of life, limb or major bodily function. A licensed physician may also request an expedited review on your behalf.

Steps in the process

1. File your request for an expedited grievance or appeal with MemorialCare Select Health Plan using one of the methods listed in the standard grievance process above. Calling Member Services is the recommended method for requesting an expedited review.
2. If your grievance or appeal has been expedited, a physician will review your request and make a determination within 72 hours. If your request does not qualify for an expedited review, your grievance/appeal will be reviewed in the standard 30-day grievance process. You will be notified by mail if you do not qualify for expedited review.
3. If you qualify for Independent Medical Review, you may appeal directly to the Department of Managed Health Care immediately.

Further Appeal Rights

If you are dissatisfied with our answer, you may be able to pursue one or more of the following appeal processes, depending on your situation and the appeal information contained in your Evidence of Coverage. If you need assistance please contact Member Services at the number on the back of your membership card.

1. File a complaint with the Department of Managed Health Care (DMHC.) Click on the following link to be directed to the DMHC web site. <http://www.dmhc.ca.gov/>. Your grievance acknowledgement letter and response letter from Seaside Health Plan will include information on how to contact the Department of Managed Health Care.
2. If your grievance involves a denial of healthcare services, you have the right to request

a second appeal from MemorialCare Select Health Plan and a different physician will review your case. You also have the option to request an Independent Medical Review from the DHMC. Information on how to file both types of review requests will be provided to you in your grievance response letter from MemorialCare Select Health Plan.

3. Seek legal remedies in a court of law.

All MemorialCare Select Health Plan Members

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 (844) 805-8700** 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) HMO-2219)** and a TDD line **(1 (877) 688-9891)** for the hearing and speech impaired. The department's Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.