

COMPLAINT FORM

Today's Date

Member ID #

Name

Address

City

State

Zip

Telephone

Name of the person filing, if different from above. _____

Relation to Complainant: _____

Date of Incident:

Description of the incidence in detail. *Attach additional sheet(s), if necessary.*

How can we resolve this incident to your satisfaction?

Attach additional sheet(s), if necessary.

Do you need language assistance? YES NO

For what spoken language: _____

Do you require accommodation(s) for any physical disabilities? YES NO

Are you in need of medical attention in the next three days? YES NO

Do have severe pain? YES NO

If you need immediate medical attention, please go to the nearest Emergency Room.

Signature of Member (Representative) Date

Signature of the Translator used for this form Date

Questions? Call 1-888-775-7888 TTY: 1-877-681-8898

Return this form to **ATTN: Member Services - Commercial Group**

By mail	445 Grant Ave San Francisco CA 94108
Or by Fax	(415)-397-2129

The Department of Managed Health Care requires that we advise our members of the following:

“The 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 plan CCHP at **(415) 834-2118 or (TTY) 1 (877) 681-8898** and use the 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 Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.”