**CANCELLATION OF HEALTH CARE COVERAGE GRIEVANCE FORM:**

**CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION OR CONTRACT**

You may use this Cancellation of Health Care Coverage Grievance Form to submit a grievance to the Department of Managed Health Care. If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free. Fill out and sign the below form, be sure to include documents requested such as notices from your health plan, billing statements, and proof of payment.

You can submit this form to:

DEPARTMENT OF MANAGED HEALTH CARE

HELP CENTER

980 NINTH STREET, SUITE 500

SACRAMENTO, CALIFORNIA 95814-2725

|  |  |
| --- | --- |
| Full Name of Subscriber: | Golden West Dental & Vision Membership ID Number (see member ID card): |
| Medi-Cal ID Number (if applicable): | Medicare or Medicare Advantage ID Number (if applicable): |
| Daytime Phone Number: | Evening Phone Number:  |
| Mailing Address: | Email Address: |

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

|  |  |
| --- | --- |
| Your Full Name: | Relationship to Subscriber (if applicable): |
|  Your Phone Number: |
| Your Address: |
| Are you the member’s authorized representative or legal guardian? Yes No |
| Did you want someone to help you with your complaint? Yes No If yes, please complete the attached “Authorized Assistance Form” |

Provide the following information about the affected enrollees:

|  |  |  |
| --- | --- | --- |
| Name | Date of Birth (mm/dd/yyyy) | Gender |
|  |  | [ ]  Male [ ]  Female [ ]  Other |
|  |  | [ ]  Male [ ]  Female [ ]  Other |
|  |  | [ ]  Male [ ]  Female [ ]  Other |
|  |  | [ ]  Male [ ]  Female [ ]  Other |
|  |  | [ ]  Male [ ]  Female [ ]  Other |
|  |  | [ ]  Male [ ]  Female [ ]  Other |

 \*document additional enrollee information in the “reason for filing the grievance” section below

|  |
| --- |
| Dental Plan Name: |
| Dental Provider Name, if applicable: |
| Employer, if applicable: |
| Date enrollee received notice that coverage was or will end: |
| Date enrollee filed a grievance with an entity other than the Department, if applicable: |
| Reason for filing the grievance:  |

Signature of Enrollee:

**In order to process your grievance, you will need to provide the following:**

Copies of plan notice(s) and correspondence(s) received, if any;

Copies of enrollee correspondence(s) sent, if any;

Copies of proof of payment for the last paid coverage period;

A Medical Release, if necessary, as follows:

**MEDICAL RELEASE**

I request that the Department of Managed Health Care (DMHC) make a decision about my problem with my plan. I request that the DMHC 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.

If you don’t know if your plan is regulated by the Department of Managed Health Care, please look at your benefits booklet. Customer service can also help you. To reach customer service, call the phone number on your member ID card.

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 **1-866-926-8078** or at the TDD line **711** for the hearing and speech impaired 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.

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

* California’s Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
* The Department’s Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
* You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
* The Department may share your personal information, as needed, with the plan, providers, and the Review Organization who conducts the IMR.
* The Department 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 Department’s Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727

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)