# 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 Group: | Anthem Billing Entity: |
| Daytime Phone Number: | Evening Phone Number: |
| Mailing Address: | Email Address: |

|  |  |
| --- | --- |
| Your Full Name: | Title: |
| Your Phone Number: |
| Your Address (if different from above): |
| Are you the group’s authorized representative? 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 member information on the attached Member Information Form.



|  |
| --- |
| Health Plan Name: |
| Medical Group Name, if applicable: |
| Date group received notice that coverage was or will end: |
| Date group filed a grievance with an entity other than the Department, if applicable: |
| Reason for filing the grievance: |

Signature of Group Administrator:

## 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 group 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.

Group Administrator:

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**](http://www.dmhc.ca.gov/) has complaint forms, IMR application forms and instructions online.

## Member Information Form

Fill out the below information for each member covered under the group plan. If more than one page is needed, you may duplicate this as needed.

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| --- | --- | --- |
| Name | Date of Birth (mm/dd/yyyy) | Gender |
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**GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET**

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

## How to File:

1. File online at [www.HealthHelp.ca.gov.](http://www.HealthHelp.ca.gov/) [This is the fastest way.]

## OR

Fill out and sign the Cancellation of Health Care Coverage Grievance Form.

1. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
2. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
3. If you are not submitting online, please mail or fax your form and any supporting documents to:

## What Happens Next?

Department of Managed Health Care Help Center

980 9th Street, Suite 500

Sacramento, CA 95814-2725

FAX: 916-255-5241

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

## INFORMATION PRACTICES ACT OF 1977 NOTICE

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

* California’s Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
* The DMHC’s Help Center uses your personal information to investigate your problem with your health plan.
* You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
* The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
* The DMHC 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 DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.