OptumHealth Physical Health of California
(ACN Group of California, Inc.)
Member Grievance Form – Large Print

If you are not satisfied with any aspect of your contact with ACN Group of California, Inc. (ACNCA), an ACNCA-Contracted Provider or its representatives including failure to provide trans-inclusive care, please complete this form and return it to the address provided on this form.

Information of Person Submitting Grievance:

Name:_____
Address:_____
City: _____ ST:____ Zip Code: _____
Phone Number: (___)_____

Relationship to Patient:

Self☐ Personal Representative☐ Employer☐
Patient's Practitioner☐ Other☐_____

Patient's Information:

Name:_____
Patient Health Plan:_____
Patient ID#:_____
DOB:_____

Treating Provider's Information:

Name: Specialty: _____
Address:_____
City: _____State:____ Zip Code: _____
Phone Number: (___)_____

Please see page 4 for important information regarding Member Grievance Rights

Please describe your grievance in as much detail as possible; include dates and names. *Please include any copies of receipts or supporting documentation as proof of services paid out of pocket.* We will notify you within five, (5) calendar days of our receipt of the grievance. We will respond in writing no later than thirty (30) calendar days of our receipt of your grievance. You can include a separate piece of paper if you need more room.

Grievance:

Please see page 4 for important information regarding Member Grievance Rights

I attest that all of the information I completed above is true.

Signature _____ Date _____

Please forward this completed form by mail to:

OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168
Attention: Grievance Coordinator

Please see page 4 for important information regarding Member Grievance Rights

California Department of Managed Health Care Notification Grievance Process and Independent Medical Review

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 **(1-800-428-6337)** or TDD **(1-888-877-5379)** 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.

If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance.

Language Assistance Services

You may be entitled to the following rights and services under California law which shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services.

Interpretation services and translated written materials are available to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. Appropriate auxiliary aids and services are also available to the member, including qualified interpreters for individuals with disabilities and information in alternate formats, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. These services will be provided free of charge in a timely manner upon request. To get help in your language, please call your health plan, ACN Group of California, Inc. at: **800-428-6337/TTY: 711**, Monday through Friday, 8:30 a.m. to 5:00 p.m. pacific time (PT). If you need more help, call the Department of Managed Health Care (DMHC) Help Center at 1-888-466-2219.

This information is available in other formats like large print. To ask for another format, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8:30 a.m. to 5 p.m.

English
IMPORTANT LANGUAGE INFORMATION:
You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. If you need more help, call DMHC Help Center at 1-888-466-2219.

Español (Spanish)
INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA:
Usted podría tener los derechos y servicios que se indican a continuación. Puede obtener los servicios de un intérprete o de traducción sin cargo. En algunos idiomas, la información escrita también podría estar disponible sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud: ACN Group of California, Inc. 1-800-428-6337 /TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la DMHC Help Center al 1-888-466-2219.

繁體中文 (Traditional Chinese)
重要語言資訊：
您可能有權享有以下權利和服務。您可以免費取得口譯或翻譯服務。書面資訊也可能免費提供某些語言版本。如欲以您的語言取得協助，請致電您的健保計劃：ACN Group of California, Inc. 1-800-428-6337 / 聽力語言殘障服務專線 (TTY)：711。**若您需要更多協助，請撥打 DMHC Help Center 協助專線**1-888-466-2219。

اللغة العربية (Arabic)
معلومات مهمة عن اللغة:
قد تكون مؤهلًا للحقوق والخدمات أدناه. يمكنكَ الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. ربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. للحصول على المساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: ACN Group of California, Inc. بولاية على الرقم 1-800-1-800- 711 :TTY/ 428-6337. إذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بمركز
المساعدة التابع لمنظمة صون الصحة (DMHC Help Center) على الرقم 1-888-466-2219.

Հայերէն (Armenian)

ԿԱՐԵՎՈՐ ՏԵՂԵՔԱՏՎՈՒԹՅՈՒՆ ԼԵԶՎԻ ՎԵՐԱԲԵՐՅԱԼ.

Դուք կարող եք օգտվել ստորև նշված իրավունքներից և ծառայություններից: Դուք կարող եք անվճար օգտվել թարգմանչի ծառայություններից: Գրավոր տեղեկատվությունը կարող է նաև անվճար հասանելի լինել որոշ լեզուներով: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական պլան հետևյալ համարով՝ ACN Group of California, Inc. 1-800-428-6337 / TTY. 711. Հավելյալ օգնության կարիքի դեպքում, զանգահարեք DMHC Help Center-ի Օգնության գիծ՝ 1-888-466-2219 h

ខ្មែរ (Khmer)

ព័ត៌មានសំខាន់អំពីភាសា៖

អ្នកអាចនឹងមានសិទ្ធិទទួលបានសិទ្ធិនិងសេវាកម្មខាងក្រោម។ អ្នកអាចទទួលបានសេវាអ្នកបកប្រែផ្ទាល់មាត់ ឬសេវាបកប្រែឯកសារដោយឥតគិតថ្លៃ។ ព័ត៌មានជាសំណេរក៏អាចរកបានជាភាសាមួយចំនួនដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលបានជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅគម្រោងសុខភាពរបស់អ្នកតាមលេខ៖ គម្រោង ACN Group of California, Inc. 1-800-428-6337 / TTY: 711។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែម សូមទូរសព្ទទៅខ្សែទូរសព្ទជំនួយរបស់ DMHC Help Center តាមលេខ 1-888-466-2219។

فارسی (Farsi)

اطلاعات مهم زبانی:

ممکن است حق استفاده از حقوق و خدمات زیر را داشته باشید. شما می‌توانید مترجم یا خدمات ترجمه بدون هزینه دریافت کنید. همچنین ممکن است اطلاعات مکتوب به برخی زبان‌ها بدون پرداخت هزینه در دسترس باشد. برای دریافت کمک به زبان خود، لطفاً با طرح سلامت خود در این آدرس تماس بگیرید ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط تلفنی کمک و راهنمایی DMHC Help Center به شماره 1-888-466-2219 تماس بگیرید.

हिंदी (Hindi)

महत्वपूर्ण भाषा सूचना:

आप निम्नलिखित अधिकारों और सेवाओं के लिए पात्र हो सकते हैं। आप मुफ्त में दूभाषिया या अनुवाद सेवाओं का लाभ उठा सकते हैं। लिखित जानकारी शायद कुछ भाषाओं में मुफ्त में उपलब्ध हो सकती है। अपनी भाषा में सहायता के लिए, कृपया अपनी स्वास्थ्य योजना से संपर्क करें: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. अगर आपको और सहायता की जरूरत है, तो DMHC Help Center हेल्प लाइन 1-888-466-2219 पर कॉल करें।

Hmoob (Hmong)

TEJ NTAUB NTAWV HAIS TXOG HOM LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai raws li cov cai thiab cov kev saib xyuas hauv qab no.Yuav pab kws txhais lus rau koj los sis txhais ntawv rau koj pub dawb.Tej zaum kuj cov ntaub ntawv sau ua qee hom pub dawb rau koj thiab.Yuav tau txais kev pab txhais ua koj hom lus, ces thov hu rau koj qhov kev npaj kho mob rau ntawm: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711.Yog koj xav tau kev pab ntxiv, hu rau DMHC Help Center Tus Xov Tooj Pab ntawm 1-888-466-2219.

日本語 (Japanese)

言語についての重要な情報：

お客様は、次のような権利およびサービスを受ける資格をお持ちかもしれません。お客様は、通訳または翻訳サービスを無料でご利用いただけます。書面による情報も、いくつかの言語にて無料でご利用いただける場合があります。日本語での支援をご希望の方は、ご利用の医療保険プランにお電話ください：ACN Group of California, Inc. 1-800-428-6337 /
TTY：711。さらに支援が必要な場合は、DMHC Help Center ヘルプライン（1-888-466-2219）にお電話ください。

한국어 (Korean)

중요한 언어 정보:

귀하는 다음의 권리와 서비스를 받을 자격이 있을 수 있습니다. 귀하는 무료로 통역사 또는 번역 서비스를 받을 수 있습니다. 서면 정보 또한 일부 언어들로 무료로 이용할 수 있습니다. 귀하의 언어로 도움을 받으시려면, 다음으로 귀하의 건강보험에 전화하십시오. ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. 더 많은 도움이 필요하신 경우, DMHC Help Center 헬프라인에
1-888-466-2219번으로 전화하십시오.

ਪੰਜਾਬੀ (Punjabi)

ਭਾਸ਼ਾ ਸੰਬੰਧੀ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਦੁਭਾਸ਼ੀਏ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਵੀ ਉਪਲਬਧ ਹੋ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ DMHC Help Center ਹੈਲਪ ਲਾਈਨ ਨੂੰ 1-888-466-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Русский (Russian)

ВАЖНАЯ ИНФОРМАЦИЯ О ЯЗЫКОВЫХ УСЛУГАХ:

Вы можете получить перечисленные ниже права и услуги. Вы можете бесплатно воспользоваться услугами устного или письменного переводчика. Письменная информация также может быть бесплатно предоставлена на нескольких языках. Чтобы получить помощь на Вашем языке, позвоните в свой план медицинского страхования: ACN Group of California, Inc., Калифорния 1-800-428-6337 / линия TTY: 711. За дополнительной помощью Вы можете обращаться в справочную службу DMHC Help Center по телефону 1-888-466-2219.

Tagalog (Tagalog)

MAHALAGANG IMPORMASYON SA WIKA:

Maaari kang maging karapat-dapat sa mga karapatan at serbisyo sa ibaba. Maaari kang makakuha ng mga serbisyo ng interpreter o pagsasalin sa wika nang walang bayad. Ang nakasulat na impormasyon ay maaari ring maging available sa ilang wika nang walang bayad. Para makakuha ng tulong sa iyong wika, pakitawagan ang iyong health plan sa: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Kung kailangan mo ng karagdagang tulong, tumawag sa Linya ng Tulong ng DMHC Help Center sa 1-888-466-2219.

ไทย (Thai)

ข้อมูลภาษาที่สำคัญ:

คุณอาจได้รับสิทธิ์และบริการดังนี้ คุณสามารถขอรับบริการล่ามหรือการแปลได้โดยไม่มีค่าใช้จ่าย ข้อมูลที่เป็นลายลักษณ์อักษรอาจมีให้ในบางภาษาโดยไม่มีค่าใช้จ่าย หากต้องการความช่วยเหลือในภาษาของคุณ โปรดติดต่อแผนประกันสุขภาพของคุณที่: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. หากคุณต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือของ DMHC Help Center ที่หมายเลข 1-888-466-2219

Tiếng Việt (Vietnamese)

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu một thông dịch viên hoặc dịch vụ phiên dịch miễn phí. Thông tin dạng văn bản cũng có thể được cung cấp miễn phí ở một số ngôn ngữ. Để được trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Nếu quý vị cần thêm trợ giúp, vui lòng gọi Đường dây trợ giúp DMHC Help Center theo số
1-888-466-2219.

State of California - Health and Human Services Agency
Department of Managed Health Care
IMR APPLICATION/COMPLAINT FORM - ENGLISH
DMHC 20-224 New: 11/15 Rev: 09/24

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: www.DMHC.ca.gov

- **FREE:** The IMR/Complaint process is free.
- **FAST:** IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- **SUCCESSFUL:** Approximately **72** percent of patients receive the requested service through IMR.
- **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name _____ Middle Initial __ Last Name _____

Patient's Date of Birth (mm/dd/yyyy) _____

Gender: ☐ Male ☐ Female ☐ Something Else _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Email Address _____

Would you like communication/correspondence sent to this email? ☐ Yes ☐ No

Health Plan Name _____ Patient's Membership # _____

Medical Group Name (if enrolled in a medical group) _____

Employer _____

Do you want someone to help you with your complaint? ☐ Yes ☐ No

If yes, please complete the attached 'Authorized Assistant Form.'

Do you have Medi-Cal? ☐ Yes ☐ No

If yes, have you filed a Request for a State Fair Hearing? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Do you want payment for a health care service that you already received? ☐ Yes ☐ No

If yes, list the date(s) of service, and the provider's name:

_____

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services? ☐ Yes ☐ No

What is your medical condition or doctor's diagnosis (Please be specific) _____

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

_____

Did your health plan deny, delay or modify your treatment? ☐ Yes ☐ No

If yes, please check the reason given: (Check one)

☐Not Medically Necessary ☐Experimental or Investigational ☐Not an Emergency/Urgent
☐Not a Covered Benefit ☐Other (Please explain below)

_____

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

_____

Have you seen any out-of-network providers for your condition? ☐ Yes ☐ No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department's 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 case. These records may also include non-medical records and any other information related to my case. I allow the Department 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 Department 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.

Patient or Parent Name (Print) _____

Patient or Parent Signature _____ Date _____

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken: _____

Would you like us to communicate/correspond with you in your primary language? ☐ Yes

Race/Ethnicity: _____

State of California - Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM - English
DMHC 20-160 New: 04/06 Rev: 01/20

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, 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 patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR 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 IMR or complaint 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.

Patient Name (Print)_____

Patient Signature_____ Date_____

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)_____

Address_____

City_____ State_____ Zip_____

Relationship to Patient_____

Primary Phone #_____ Secondary Phone #_____

Email Address_____

☐ My power of attorney for health care decisions or other legal document is attached.

IMR Application/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.

Before You File:

In most cases, you must complete your plan's complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan's complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DEPARTMENT for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to File:

1. File online at www.DMHC.ca.gov. [This is the fastest way.]
   OR
   Fill out and sign the IMR Application/Complaint Form.
2. If you want someone to help you with your IMR or complaint, complete the 'Authorized Assistant Form.'
3. If you have medical records from ***out of network*** *providers*, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.
4. You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The Department will obtain this information directly from your plan as part of the investigation.
5. If you are not submitting online, please mail or fax your form and any supporting documents to:
   Department of Managed Health Care Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center's possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

If it is determined that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

IMR Application/Complaint Form Instruction Sheet

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 and providers who conduct 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 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.