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 ., an ACN-Contracted Provider or its representatives please complete this form and return it to the address provided on this form.

Information of Person Submitting Grievance:

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

Relationship to Patient:
0 Self 0 Personal Representative 0 Employer 0 ____
Patient's Practitioner 0 Other

Patient's Information:

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

Treating Provider's Information:

Name: Specialty: _____
Address: _____
City: ST _____ 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 for TDDY services call 1-(888) 877-5379 (voice), or 1-(888) 877-5378 (TDDY)** 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 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 (http://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.

OPTUMHealth®
Physical Health of California

California Language Assistance Program Notice

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 HEALTH PLAN Help Line at 1-888-466-2219.

Spanish

INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de ACN Group of California, Inc. al 1-800-428-6337 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HEALTH PLAN al 1-888-466-2219.

Chinese

重要語言資訊：

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：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 HEALTH PLAN 協助專線 1-888-466-2219。

Arabic

معلومات مهمة عن اللغة:

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنكَ الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: ACN Group of California, Inc. على الرقم 1-800-428-6337 / TTY: 711. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HEALTH PLAN على الرقم 1-888-466-2219.

Armenian

ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ ACN Group of California, Inc. 1-800-428-6337 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HEALTH PLAN-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

Cambodian

ព័ត៌មានសំខាន់អំពីភាសា៖

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសា របស់អ្នក សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក នៅ៖ ACN Group of California, Inc. 1-800-428-6337 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HEALTH PLAN តាមលេខ 1-888-466-2219។

Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی نیز ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: ACN Group of California, Inc. به شماره 1-800-428-6337/TTY: 711 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HEALTH PLAN به شماره 1-888-466-2219 تماس بگیرید.

Hindi

भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्न□ल□खित अ□धकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में एक दुभा□षया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में □ल□खित जानकारी भी मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के □लए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711 पर। यदि आपको अ□धक सहायता की आवश्यकता हैं, तो HEALTH PLAN Help Line को 1-888-466-2219 पर कॉल करें।

Hmong

NCAUJ LUS TSEEM CEEB TXOG KEV TXUAS LUS:

Tej zaum koj yuav tsim nyog tau cov cai thiab kev pab cuam hauv qab no. Koj yuav tau ib tug kws txhais lus los sis txhais ntawv pub dawb. Yuav puav leej txhais tau cov ntaub ntawv ua qee hom lus pub dawb. Kom tau kev pab rau koj hom lus, thov hu rau qhov chaw pab them nqi kho mob rau rau koj ntawm: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HEALTH PLAN Help Line ntawm tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ：

お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください：ACN Group of California, Inc. 1-800-428-6337 / TTY: 711。この他のサポートが必要な場合には、HEALTH PLAN Help Line に 1-888-466-2219 にてお問い合わせください。

Korean

중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. 더 많은 도움이 필요하신 분은 HEALTH PLAN 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: `ACN Group of California, Inc. 1-800-428-6337 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HEALTH PLAN ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

Russian

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: ACN Group of California, Inc. 1-800-428-6337 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HEALTH PLAN по телефону 1-888-466-2219.

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HEALTH PLAN Help Line sa 1-888-466-2219.

Thai

ข้อมูลสำคัญเกี่ยวกับภาษา :

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : ACN Group of California, Inc. 1-800-428-6337 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HEALTH PLAN ที่หมายเลขโทรศัพท์ 1-888-466-2219

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 được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HEALTH PLAN theo số 1-888-466-2219.

State of California
Health and Human Services Agency
Department of Managed Health Care
IMR APPLICATION/COMPLAINT FORM – English Clarify
DMHC 20-224 New: 04/06 Rev: 08/18

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: www.HealthHelp.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 **60** 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 ☐ Other _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Email Address _____

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

Health Plan Name _____ Patient's Membership # _____

Medical Group Name (if 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 health 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

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 Clarify
DMHC 20-160 New: 04/06 Rev: 08/18

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. **(Both parties must sign the form)**
- If you are a parent or legal guardian filing this IMR/Complaint Form 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) _____

Signature of Person Assisting _____

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 Department at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

Before You File:

In most cases, you must go through your health plan's complaint or grievance process before you file a complaint or IMR request with the Department. Your health 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 health plan denied your treatment because it was experimental/investigational, you do not have to take part in your health 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. You can still file your application after six months if there were special circumstances that kept you from filing timely. 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.HealthHelp.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.' **Both you and your authorized assistant must sign the 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 letters 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 Department will determine if your case qualifies as an IMR or a complaint. Cases qualify for an IMR if health care services were delayed, modified or denied based on a medical necessity or as experimental/investigational.

Cases that do not qualify for an IMR are processed through the consumer complaint process. These cases involve issues such denials of health care service as not a covered benefit, claim payment disputes, cancellation of coverage, quality of care, and deductible/out of pocket expenses.
The Department will send you a letter within seven days telling you if you qualify for an IMR. If the Department decides 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 called the Independent Medical Review Organization (). All of the information the Help Center has related to your complaint,

including your medical records, will be sent to the Review Organization. The Review Organization will make a decision usually within 45 days, or within seven days if your case is urgent. The Department will send you a letter with the decision.

If the Department decides that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. The Department will send you a letter with the decision.

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.