Grievance Form for Cancellations, Rescissions and Nonrenewals of an Enrollment or Subscription

You may mail this form to:

Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814

You may also submit online at www.HealthHelp.ca.gov.

Name of enrollee, subscriber or group contract holder filing the grievance:

Gender
Male Female Other **Date of Birth** *(of person filing grievance)*:

Mailing Address: **City:** **State:** **ZIP:**

Daytime Phone: **Evening Phone:** **Email Address:**

Name(s) and Health Plan ID n**umber of all enrollees impacted:**

Name of Parent or Guardian *(if filing for minor child)*: **Health Plan Name:**

Group Name: **Employer Name:**

Date enrollee received notice that coverage was ended or will end:

Date enrollee filed a grievance with an entity other than the DMHC *(if applies)*:

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.

Enrollee, Legal Guardian or Parent Signature: **Date:**

Grievance/Complaint Form Instructions

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 OR

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

2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.

3. 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.

4. 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

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.

The Information Practices Act of 1977 Notice, as follows:

The California 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 give the DMHC this information voluntarily. You do not have to give 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.

Explanation of reason for filing the grievance:

Signature of enrollee:

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:

Email Address:

Relationship to Enrollee:

Daytime/Evening Phone Number:

This Authorized Assistant Form is valid only for matters related to this specific appeal/grievance. My approval of an authorized representative is voluntary. I can end this authorization, in writing, at any time.

Signature (Member):

Date:

I accept the appointment to act as this individual's representative in this appeal/grievance with the DMHC or Dental Benefit Providers of California, Inc. I understand this Authorized Assistant Form is valid only for matters related to this specific appeal/grievance.

Please send this Authorized Assistant Form with your completed Grievance Form.

When submitting to the DMHC, send form to:
Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
Fax: 916-255-5241

When submitting standard and expedited grievances/appeals to the Plan, send form to:

Dental Benefit Providers of California, Inc. Attn: Appeals & Grievances
P.O. Box 30569
Salt Lake City, UT 84130-0569
Telephone: 1-800-445-9090 (TTY: 711) Fax: 714-364-6266