Grievance Form for Cancellations, Rescission, Non-Renewal

For a grievance about a cancellation, rescission, or nonrenewal of health care coverage**,** you or your authorized representative can file one using this form. If you want to give another person permission to help you complete the form, please fill out the "Authorized Assistant" sections on pages 3 & 4. You will find instructions on what sections to complete. Use this form and submit it either electronically or by mail or fax to the address or website below. You may also call the Department with your grievance. The number is below.

Department of Managed Health Care
Center 980 9th Street, Suite 500
Sacramento, CA 95814-2775

Online: File online at: **www.dmhc.ca.gov**

Fax to:

(916) 255-5241

Call: The Department has a toll-free telephone number [1-888-HMO-2219] and a TDD line [1-877-688-9891] for the hearing and speech impaired.

The Help Center will send a letter telling you if your grievance has been accepted. If it's accepted, a decision will be made within 30 days. You will be notified in writing of the decision. For questions about your grievance, you may call the Help Center number above.

Enrollee Information	
First name	Middle initial:
Last name:	Birthdate (MM/DD/YYYY): (/ /)
Male ☐ Female ☐ Other ☐	
Gender	
Name of parent or guardian if filing for minor child enrollee:	
Mailing address:	
City:	State: ZIP code:

Daytime phone number: 1- (XXX) (XXX) (XXXX)	Evening phone number: 1- (XXX) (XXX) (XXXX)
Email address:	
Health plan name:	Member ID
Medical group name (if applicable):	Employer (if applicable):
Medi-Cal ID # (if applicable):	Medicare ID # (if applicable):
Group contractholder/Plan Sponsor name	Attach separately: Name(s) and ID number(s) of all affected members

Summary of Grievance Issue

Please explain the issue you have related to your health plan coverage and the cancellation, rescission or non-renewal of your health plan. Use additional pages and attach other documents, if needed.

Have you filed a grievance with your health plan? ☐ Yes ☐ No If yes, list the date the grievance was filed with your health plan (MM/DD/YYYY): (/ /)	Have you filed a grievance with an entity other than the DMHC? ☐ Yes ☐ No If yes, list the date the grievance was filed with another entity (MM/DD/YYYY): (/ /)

Have you received notice from your health plan that coverage was ended or will end?

☐ Yes ☐ No

Date you received notice that the coverage was ended or will end: (MM/DD/YYYY):

(/ /)

Attach copies of plan notice(s) and correspondence received, if any

Attach copies of proof of payment for the last coverage period

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

If yes, please complete the attached "**Authorized Assistant Form**" on the following pages.

Medical Release

I request the Department of Managed Health Care (DMHC) to make a decision about my problem with my health plan. I request the DMHC to review my Cancellation of Health Care 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 name (print):	Enrollee, legal guardian or parent signature: X	Date (MM/DD/YYYY): (/ /)

Please see the instructions on page 1 for mail and fax information.

Authorized Assistant Form

If you want to give another person permission help with your grievance, complete Parts A and B below.

(Both parties must sign the form).

- If you are a parent or legal guardian filing this grievance form for a child under the age of 18, you do not need to complete this form.
- If you are filing this grievance for a member who cannot complete this form because the member 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: Completed by Member

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.

Member name (print):	Member signature: X	Date: (MM/DD/YYYY):
Part B: Completed by Person Assisting Enrollee		
Name of person assisting (print):	Signature of person assisting: X	
Mailing address:		
City:	State:	ZIP code:
Relationship to enrollee:		
Daytime phone number:		
Evening phone number:		
Email address (if available):		
Is your power of attorney for health care decisions or other legal document attached? ☐Yes☐ No		

Information Practices Act of 1977 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 health 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's Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call **(916) 322-6727**.

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- 445-5299, unless you have an urgent grievance, 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 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 web site http://www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.