COMMUNITY CARE HEALTH

Grievance Form for Cancellations, Rescissions, & Nonrenewal of Enrollment or Subscription

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1) - YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

- You may submit a grievance to Community Care Health by calling 1 (855) 343-2247 (TTY: 1 (800) 735-2929), online at www.communitycarehealth.org, or by mailing your written grievance to P.O. Box 45026, Fresno, CA 93718.
- You may want to submit your grievance to Community Care Health first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- Community Care Health will resolve your grievance or provide a pending status within 3 calendar days. If you do not receive a response from the plan within 3 calendar days, or if you are not satisfied in any way with the plan's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.
- You may submit a grievance to the Department of Managed Health Care online at: WWW.HEALTHHELP.CA.GOV
- You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:
  HELP CENTER
  DEPARTMENT OF MANAGED HEALTH CARE
  980 NINTH STREET, SUITE 500
  SACRAMENTO, CALIFORNIA 95814-2725
- You may contact the Department of Managed Health Care for more information on filing a grievance at:
  Phone: 1 (888) 466-2219
  TDD: 1 (877) 688-9891
  Fax: 1 (916) 255-5241

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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 Member ID number(s) of all enrollees impacted

_____

_____

_____

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

_____

Medical Group Name Employer Name (if applicable)

_____

Date enrollee received notice that coverage was or will end

_____

Date enrollee filed a grievance with an entity other than the DMHC (if applicable)

_____

Details of your complaint, please be as specific as possible with dates, times, the problem, and the reason you are filing this grievance: Include copies of the Notice of Cancellation, Rescission or Nonrenewal from Community Care Health, billing statements, proof of payments for the last paid coverage period, and any other information related to your compliant. You may use the other side of this form or additional sheets if needed.

_____

_____

_____

_____

_____

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.

X _____ _____

Enrollee, Legal Guardian, or Parent Signature Date

Please see the instruction sheet for mailing or faxing information.

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.

X _____ _____

Enrollee Signature Date

PART B: PERSON ASSISTING ENROLLEE

Name of Person Assisting (print): _____

Signature of Person Assisting: _____

Street Address, City, State, Zip: _____

Relationship to Enrollee: _____

Daytime Phone Number: _____ Evening Phone Number: _____

Email Address (if available): _____

My power of attorney for health care decisions or other legal document is attached: ☐ (check if applicable)

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. [This is the fastest way.]
   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

What Happens Next?

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.