Member Grievance and Appeal Form

Phone: **1-888-421-8444** Fax: **1-408-885-4425**
2480 N. First Street, Suite 160, San Jose, CA 95131

This form is optional. Valley Health Plan can help you fill out this form. You may also file a grievance verbally by calling us at **1-888-421-8444**, 9:00 a.m. to 5 p.m. (PST), Monday – Friday, TTY/TDD should utilize **711** or send email to MemberServices@vhp.sccgov.org. Someone will contact you by phone when this form is received. We will assist you in any way we can and answer any questions that you have. We can help you in any language.

Member Contact Information

Member Name: _____

Member ID: _____ **Date of Birth:** _____

Member Address: _____

Daytime phone number: _____ **Evening phone number:** _____

Email: _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

Contact Information for Guardian or Non-Grieved Party

Name of guardian or individual filling, if different from member: _____

Relationship: _____ **Contact number:** _____

Email: _____

Explanation of Issue

Describe the problem in detail:

_____

_____

_____

What would you like someone to do about the problem?

_____

_____

_____

Will you need language assistance? ☐ **Yes** ☐ **No** **If yes, language preference:** _____

Do you require medical attention within the next three days or are you in severe pain? ☐ **Yes** ☐ **No**

_____

_____

_____

Date Member filled a grievance with another entity, if applicable: _____

Is this grievance related to the termination of medical coverage? ☐ **Yes** ☐ **No**
If yes, provide date Member received notice that coverage was or will end: _____

Please provide any supporting documents with this form, such as plan notice(s) and correspondence(s), billing statements, and proof of payment.

Signature*: _____ **Date:** _____
If signed by somebody other than the Member, a Personal Representative (PR) Form is required.

For Internal Use Only

Received by:_____ Date: _____

Date Member Notified Form Received: _____

Date Member Acknowledgement Letter Sent: _____

Case/Call Tracking Number:_____ ☐ *Appeal* ☐ *Grievance*

The Department of Managed Health Care requires Valley Health Plan to inform you of the following:

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 **1-888-421-8444** 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 web site **http://www.dmhc.ca.gov/** has complaint forms, IMR application forms and instructions online.