Mail to:
Contra Costa Health Plan
Member Services
595 Center Ave., Ste. 100
Martinez, CA 94553
Call or Fax:
1-877-661-6230, Press 2
Fax: 925-313-6047
Email:
member.services@hsd.cccounty.us
www.contracostahealthplan.org

Member Grievance or Appeals Form

Member Name:_____ Date of Birth: _____

Member Identification Number:_____ Phone:_____

Address: _____

Information needed to file a Grievance

Date of Service:_____ Location of Service: _____

Briefly Describe Complaint (Please include as much detail as possible including names of the people involved, the circumstances leading up to the conflict, and any information you feel is important to the complaint):

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What action are you requesting?

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Over for additional Information

Information Needed to File an Appeal

- Appeal/Reconsideration requests can be made to the Health Plan by the member if they have received a Notice of Action (NOA) letter concerning a denial of a claim or a delay, modification, or denial of a requested service.
- The request can be made by phone or on-line ***but must be followed up in writing and signed by the member or the member's legal representative.***
- For our Medi-Cal members this request must be made within 60 days of receipt of a NOA.
- For our Commercial member this request must be made within 180 of a receipt of a NOA.

Date of Notice of Action (NOA) Denial Letter: _____

Description of a Regular Appeal

Please include as much detail as possible including date of the denial of the claim or service and any additional information you feel is important to consider. The Health Plan has 30 days to respond to your appeal and you will get a final notice of resolution:

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Description of an Expedited Appeal

If you think waiting 30 days for the Health Plan to respond, will hurt your health, you might be able to get a response within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an "expedited appeal". Please include as much detail as possible including date of the denial of service and any additional information you feel is important to consider. The Health Plan has 72 hours to respond to your expedited appeal and you will get a final notice of resolution:

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I authorize that all information pertaining to this grievance/appeal, possibly including medical records and clinical information, be shared with the Contra Costa Health Plan for the express purpose of resolution of this grievance.

Member Signature Date

Name of Person Submitting Grievance/Appeal Relationship Date Phone

If not signed by member or member's legal guardian, we will be unable to process grievance/appeal without member's explicit agreement.

If your prefer you may print out this form and submit it in writing to:

Contra Costa Health Plan
Member Services Dept.
Attn: Grievance / Appeal
595 Center Ave. Ste. 100
Martinez, CA 94553

Email: member.services@hsd.cccounty.us
www.contracostahealthplan.org

FILING A COMPLAINT WITH DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

Department of Managed Health Care (DMHC)
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 (**Contra Costa Health Plan 1-877-661-6230 Press 2**)) 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 website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.