



Community Health Plan
LOS ANGELES COUNTY

Primary Care Site Name: _____

Member ID Number: _____

Grievance Code: _____

GRIEVANCE FORM

MEMBER INFORMATION

Member Name (Last)	(First)	Birth Date:	Mo.	Day	Yr.	Effective Date of Enrollment:	Mo.	Day	Yr.	
Address (Street)		(City)			(State)		(ZIP Code)			
Telephone (Home)		(Work)				Number of Plan Members in Family, Including Member Grievance:				
Name of person completing form, if different from member name						(Daytime Telephone)				

Where did the problem occur? (Name of Pharmacy, Hospital or Clinic)	Date of Incident:	Mo.	Day	Yr.
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Who was involved beside yourself? (Give names of involved staff, if possible.)

Please describe what happened as specifically as possible: (Include the sequence of events and how the problem affected you.)

See Attachment

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against Community Health Plan, you should first telephone Community Health Plan at **1-800-475-5550** (TDD/TTY for the hearing impaired at **1-800-353-7988**) and use Community Health Plan's grievance process before contacting the DMHC. 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 Community Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 of Managed Health Care also 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 Department's Internet web site, <http://www.hmoHELP.ca.gov>, has complaint forms, IMR application forms, and instructions online.

ACTION REQUESTED

Resolved within 24 hours? Yes No

What would you like to see done about this problem?

See Attachment

Grievance Received By:	In Person <input type="checkbox"/>	<p>_____ Date</p> <p>Member's Signature (optional)</p> <p>I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION REGARDING MY COMPLAINT.</p>
	By Telephone <input type="checkbox"/>	
Date Received: Time Received	By Mail <input type="checkbox"/>	
	Online <input type="checkbox"/>	



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DESCRIBE WHAT HAPPENED:

ACTION REQUESTED:

(OFFICIAL USE ONLY)

OUTCOME/RESOLUTION:

(Complete only if an Expedited Appeal)

Member was acknowledged verbally and notified of the 72 hours appeal process: Yes No

Grievance Received by:

Date Received: