Date ______________________

GRIEVANCE FORM

Subscriber Name ______________________ **Subscriber Number** ______________________

Contact Name ______________________ **Relationship to Subscriber** ______________________

Address ____

____

Home Telephone ______________________ **Day Phone** ______________________

____

Patient signed authorization if contact is other than the patient. This signature allows Blue Shield to communicate directly with the Contact person noted above, providing the Contact person with information relative to the concerns outlined in this grievance.

Preferred means of communication: ☐ **U.S. Mail** ☐ **Email to** ______________________

Patient Name ______________________ **Date(s) of Service** ______________________

Claim Number ______________________ **Provider Name** ______________________

Billed Amount $ ______________________

Please describe your grievance providing as much detail as possible. Use additional pages if necessary. Attach any related documentation to this form. Please mail the completed form and attachments to the Member/Customer Service Department at the address located in your Evidence of Coverage (EOC).

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Original – Blue Shield
Copy – Member

PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION

GRIEVANCE PROCEDURE / REQUEST FOR APPEAL

If you are not satisfied with the Customer/Member Services Department response to your inquiry, you (or your provider or a representative on your behalf) may request an appeal by 1) calling the Customer/Member Services Department toll-free telephone number, 2) writing to the Customer/Member Services Department, or 3) by submitting a completed Grievance Form. A Grievance Form can be obtained either by contacting Customer/Member Services or by logging on to https://www.mylifepath.com/. The completed Grievance Form should be submitted to the Customer/Member Services Department. Appeals are resolved within 30 calendar days.

The grievance system allows you to file grievances for at least 180 days following an incident or action that is subject to your dissatisfaction.

The Department of Managed Health Care Notification

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 by calling your Customer/Member Services Department and use you 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-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.

Independent Medical Review (IMR) through the Department of Managed Health Care / Voluntary Appeal Procedure

Effective January 1, 2001, members have the right to request an Independent Medical Review through the Department of Managed Health Care (DMHC), as indicated in the above paragraph. The Independent Medical Review applies to services that are denied, modified or delayed by a decision of the plan that a service is not medically necessary or is considered experimental and/or investigational. Members must a) have a provider recommending the treatment that is being sought, b) have received medically necessary urgent or emergency care from a provider, even though the provider may not be recommending the treatment. Members can contact the Department of Managed Health Care (DMHC) directly.

Employee Retirement Income Security Act (ERISA) Notification

If your employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved.

You are entitled to, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation.