Santa Clara Family Health Plan

Member Grievance Form

Phone: **1-800-260-2055**

Fax: **1-408-874-1962**

Office Hours: 8:30 a.m. to 5 p.m., Monday – Friday

This form is optional. Santa Clara Family Health Plan can help you fill out this form or you may file a grievance verbally by calling us at **1-800-260-2055**, 8:30 a.m. to 5 p.m., Monday – Friday. TTY/TDD users should call **1-800-735-2929**. Or, someone will contact you by phone as soon as we receive this form. We will assist you in any way we can and answer any questions that you have. We can help you in any language.

Member Name: _____

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

Address: _____

Home Phone: _____ **Work/Cell Phone:** _____

Name of person filing if different from above: _____

Relationship: _____ **Telephone:** _____

Date of Problem: _____

Describe the problem in detail:

_____

_____

_____

What would you like someone to do about the problem?

_____

_____

_____

Will you need language assistance?

☐ Yes ☐ No Language preference: _____

Do you have a problem that needs medical attention in the next three days, or are you in severe pain?

☐ Yes ☐ No

_____

_____

_____

Signature*: _____ **Date:** _____

*If signed by somebody other than the Member, an Authorized Representative Form (ARF) is required.

SCFHP USE ONLY

☐ Grievance ☐ Appeal **SCFHP RECEIPT DATE:** _____

FOR INTERNAL USE ONLY

Received by: _____ **Date:** _____

Referred to: _____ **Date:** _____

Information/Resolution:

_____

_____

_____

Patient Notified: ☐ Yes ☐ No

Notified by: _____ **Date:** _____

Special assistance provided (language, transportation):

_____

_____

_____

The Department of Managed Health Care requires Santa Clara Family 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 **1-800-260-2055** 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-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.

As a Medi-Cal beneficiary:

You can request a State Fair Hearing. If you decide to request a hearing, you must do so within 90 days of the mailing of your notice. Please contact Santa Clara Family Health Plan for the forms that you need. They are also available from the Santa Clara County Department of Social Services.

Information about the State Fair Hearing process is also available by writing:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Or by calling **1-800-952-5253** or TDD **1-800-952-8349**.