California Medicare +Choice Plan Member
Appeal & Grievance Form

(*Non-Medicare + Choice members should use the "California Managed Care Member Grievance Form*")

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. Your health plan **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call the Customer Services department of your provider group and/or your health plan's Customer Service department. Health plan customer service contact information is provided on the back of this sheet, and may also be found on your health care card.

Please print or type the following information:

____
Member Name (Last, first, middle initial)

______________________________ ______________________
Address | Home Phone number

______________________________ ______________________
City, State, Zip | Work Phone number

______________________________ ______________________
Name of Employer or Group | Enrollment ID #

______________________________ ______________________
Date of Birth | Male/Female

Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:

Name: ______________________________ Telephone # ___________________________

Relationship to Member: ____

Address: ____

City: ________________________________ State: __________ Zip: ____________

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

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Please sign and MAIL TO your health plan (see page # 2 for health plan addresses)

Date_______________ **Signature**____

Date_______________ **Signature of Representative**___________________________

Send your Medicare +Choice Patient Appeal and/or Grievance Letter to your health plan at:

Health Plans:	Phone/Fax
Aetna U.S. Healthcare Attn.: Grievance & Appeals P.O. Box 1918 Rancho Cucamonga, CA 91729-1918	800-282-5366 Member Service 800-932-2159 Expedited 72/hr only Fax: 909-476-5216
Blue Cross Senior Secure Attn.: Grievance & Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310	888-230-7338 Member Services Fax: (818) 234-4084
California Medicare Advantage Attn: Grievance & Appeals 18000 Studebaker Road Suite 100 Cerritos, CA 90703	888-494-8280 Member Services Fax: 562-741-4414
Chinese Community Health Plan Att: Member Services 170 Columbus, Suite 210 San Francisco, CA 94133	415-397-3190 415-397-2129 sdeckinger@cchphmo.com
HealthNet Seniority Plus Attn: Appeals & Grievances P.O. Box 10344 Van Nuys, CA 91410-0344	800-275-4737 Fax: 818-676-8179
InterValley Health Plan Attn: Seniors Appeals Dept. P.O. Box 6002 Pomona, CA 91769-6002	800-251-8191 Fax: 909-620-6413
SCAN Health Plan Attn: Grievance and Appeal Department 3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90801	800-559-3500 (M-F 7am to 6pm) Fax: 562-989-0958 TDD-TTY: 800-735-2929
Secure Horizons Attn: Appeals, Mail Stop CY44-157 P.O. Box 489 Cypress, CA 90630 Secure Horizons Attn: Expedited Appeals, Mail Stop CY44-157 P.O. Box 489 Cypress, CA 90630-0489	800-228-2144 or 714-226-6809 Fax: 714-226-8804Std 888-277-4232 Fax: 714-226-8898 Expedited
Western Health Advantage Attn: Member Services, 1331 Garden Highway, Ste 100 Sacramento, CA 95833	888-563-2250 Fax #: 916-568-0126 TDD-TTY: 888-877-5378
For Hospital/SNF Stays: California Medical Review, Inc. (CMRI), Citicorp Bldg. One Sansome Street, Ste. 600 San Francisco, CA 94104-4448	800-841-1602 Fax: 415-677-2195

Information for all Medicare +Choice Members (OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001):

You may have the right to appeal.

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at: (___) ________ to learn how to name your authorized representative.
If you have a hearing or speech impairment, please call us at TTY/ TDD (___) ________ .

If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call your plan or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can File:

Standard (30 days) - You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include With My Appeal?
You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service.
Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to your health plan at the address indicated on the California Medicare + Choice Plan Member Appeal & Grievance Form.

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax using the plan contact information indicated on the California Medicare + Choice Plan Member Appeal & Grievance Form.

What Happens Next? If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare +Choice Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Other Contact Information:
If you need information or help, call us at:

Other Resources To Help You:
Medicare Rights Center:
Toll Free: 1-888-HMO-9050
TTY/TTD:

Elder Care Locator
Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)
TTY/TTD: 1-877-486-2048

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