State of California
Health and Human Services Agency
Department of Managed Health Care
CONSUMER COMPLAINT FORM-English
DMHC 20-081 New: 01/02 Rev: 03/09

COMPLAINT FORM

Complete and sign this form if you filed a complaint or grievance with your health plan and:

- You are not satisfied with your plan's decision *or*
- You have not received your plan's decision within 30 days.

If you want to give another person the authority to assist you with your complaint, you must also complete the Authorized Assistant Form.

If your complaint is about a serious health risk, call the Department of Managed Health Care's (DMHC) Help Center now. Calls to these numbers are free.

1-888-466-2219 TDD 1-877-688-9891

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Daytime Phone # _____ Evening Phone # _____

Health Plan Name _____

Patient's Membership Number* _____ Patient's Date of Birth (mm/dd/yy) _____

Medical Group Name* _____ Medical Group Number* _____

**on your insurance card*

1. Do you have Medi-Cal? ☐ Yes ☐ No
2. Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No
3. Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No
4. Did your health plan cancel your insurance? ☐ Yes ☐ No
5. Please explain your complaint: (use a separate sheet if necessary)

For example: What service did you want from your health plan, or provider?
What was wrong with the service you got from your health plan, or provider?
What billing problem do you have with your health plan, or provider?

_____

_____

_____

6 What is your health problem or diagnosis related to this complaint?

_____

_____

7 What treatment(s) have you had for this health problem?

_____

_____

8 Please list the providers who have treated you for your health problem, if you have their names.

_____

_____

9 Have you filed another complaint about this problem with the DMHC Help Center or another government agency?

☐ With the DMHC Help Center? Complaint File # (if known) _____

☐ With another government agency? Complaint File # (if known) _____

Please list government agency: _____

10 Attach **copies** of documents related to your complaint, such as denials, your grievance to the health plan and its response, bills, explanations of benefits, and any medical records from non-contracted providers.

We cannot return originals.

11 I am asking the Department of Managed Health Care (DMHC) to help make a decision about my problem with my health plan. I understand that a copy of my complaint and medical records will be sent to my health plan. I allow my providers, past and present, and my health plan to release my health records to the DMHC. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the DMHC to review these records and information. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Authorized Assistant Form attached? ☐. Yes ☐. No

Patient or Parent Signature _____ Date _____

Mail or fax your form and any attachments to: **Help Center, Department of Managed Health Care, Complaint Unit, 980 9th Street, Suite 500, Sacramento, CA 95814; FAX: 916-255-5241**

State of California
Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM
DMHC 20-160 New: 04/06 Rev: 12/08

AUTHORIZED ASSISTANT FORM

- If you want to give another person the authority to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (DMHC). I allow the DMHC and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Signature _____ Date _____

PART B: PERSON ASSISTING PATIENT

Name of Person Assisting (print) _____

Signature of Person Assisting _____

Address _____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

☐. My power of attorney for health care decisions or other legal document is attached.

Department of Managed Health Care Help Center

THIS NOTICE IS REQUIRED BY LAW*

California's Knox-Keene Act gives the Department of Managed Health Care (DMHC) the authority to regulate health plans and investigate the complaints of health plan members.

- The DMHC's Help Center uses your personal information to investigate your problem with your health plan and to provide an Independent Medical Review if you qualify for one.
- You give us this information voluntarily. You do not have to give us this information.
- However, if you do not give us the information, we may not be able to investigate your complaint or provide an Independent Medical Review.
- We may share your personal information, as needed, with the health plan and the doctors who are doing the Independent Medical Review.
- We may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, 916-322-6727.

* The law that requires this notice is the Information Practices Act of 1977 (California Civil Code Section 1798.17).