Member Complaint/ Grievance Form

California

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) 877-7195** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

If you are a Medi-Cal patient: You may request a DHS Fair Hearing by contacting the Department of Social Services (DSS) at **1 (800) 952-5253** within 90 days after the order or action complained of. A Fair Hearing is an administrative procedure in which you can present your concern directly to the State of California. If you decide to request a Fair Hearing, you may represent yourself at the hearing or you may be represented by another person such as an attorney, friend, advocate, relative, or any person you choose. DSS can help you obtain a Legal Aid lawyer, free of charge, to help you with your Fair Hearing.

Member Complaint/ Grievance Form

California

When you're not happy, we're not either. We'd love the opportunity to hear from you, and the chance to make it right. If you'd rather call or complete our **GRIEVANCE FORM**, call us at **1 (800) 877-7195** or visit our website at **www.vsp.com**.

YOUR INFORMATION

Primary Member First/Last Name________________________________

Last 4 of SSN or Member ID#________________________________

Date of Birth____________________

Phone Number____________________ Email Address____________________

Address ________________________________

City____________________ State__________ ZIP__________

Client Name, Employer, or HMO________________________________

Patient First/Last Name________________________________

Your relationship to the parent: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________

Are you an authorized representative for this patient? ☐ Yes ☐ No

DOCTOR DETAILS ☐ This grievance is not related to a doctor's visit.

Doctor Name____________________ Date of Service__________

Doctor Phone____________________

What's on your mind?________________________________

____

____

How can we help?________________________________

____

____

Is your grievance related to a violation of Privacy or Security of Health Information (HIPPA)? ☐ Yes ☐ No

Send this to **VSP™, Attn: Complaint & Grievance Unit, PO Box 997100, Sacramento, CA 95899-7100**.
Once we receive this form, you'll receive an acknowledgement letter within five calendar days and a resolution letter within 30 calendar days.

©2022 Vision Service Plan. All rights reserved.
VSP is a registered trademark of Vision Service Plan. All other brands or marks are the property of their respective owners. 105112 VCCM

Classification: Confidential