blue california | Promise Health Plan

GRIEVANCE FORM

MEMBER INFORMATION

Member Name (Last) (First)	Birth Date: Mo. Day Yr.	Effective Date of Enrollment: Mo. Day Yr.
Address (Street) (City) (State)		(ZIP Code)
Telephone (Home)	(Work)	Number of Plan Members in Family, Including Member Grievance:
Name of person completing form, if different from member name		(Daytime Telephone)

Where did the problem occur? (Name of Pharmacy, Hospital or Clinic)	Date of Incident: Mo. Day Yr.
Who was involved beside yourself? (Give names of involved staff, if possible.)	
Please describe what happened as specifically as possible: (Include the sequence of events and how the problem affected you.) **See Attachment**	

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against Blue Shield Promise, you should first telephone Blue Shield Promise at **1-800-605-2556** (TDD/TTY for the hearing impaired at **1-877-735-2929**) and use BSCPHP's grievance process before contacting the DMHC. 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 Blue Shield Promise, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 of Managed Health Care 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 on-line.

ACTION REQUESTED

What would you like to see done about this problem?

See Attachment

Grievance Received By:	In Person ☐	
	By Telephone ☐	
Date Received: Time Received	By Mail ☐	Member's Signature (optional) Date
	Online ☐	I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION REGARDING MY COMPLAINT.

Rev. 0509

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DESCRIBE WHAT HAPPENED:

ACTION REQUESTED:

(OFFICIAL USE ONLY)
OUTCOME/RESOLUTION:
(*Complete only if an Expedited Appeal*)
Member was acknowledged verbally and notified of the 72 hours appeal process: Yes ☐ No ☐
Grievance Received by: **Date Received:**