

**HEALTHY KIDS
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
REQUEST FOR APPEAL OR COMPLAINT FORM**

Date: _____

Member's Name: _____

Address: _____

Member's Phone Number: _____

PHC ID #: _____

Please tell us about your appeal or complaint: _____

What can the HealthPlan do to help solve this problem? _____

**Complaints and Appeals must be filed within 180 calendar days following any
incident or action that you are not satisfied with.**

**Please mail or bring this appeal or complaint to:
Partnership HealthPlan of California
360 Campus Lane, Ste., 100
Fairfield, CA 94534
Attn: Grievance Coordinator**

You may also make your appeal or complaint by telephone. Contact the Partnership HealthPlan of California's Member Services Department at (707) 863-4120 or 800-863-4155. Hearing and speech impaired members should call 800-735-2922.