

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA REQUEST FOR APPEAL OR COMPLAINT FORM

Date: \_\_\_\_\_

Member's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Member's Phone Number: \_\_\_\_\_

ID Number on your PHC or Medi-Cal Card: \_\_\_\_\_

Please tell us about your appeal or complaint: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What can the HealthPlan do to help solve this problem?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Complaints must be filed within 180 calendar days following any incident  
Appeals regarding an adverse Notice of Action must be filed within 90 calendar days from  
the date of the notice**

**Please mail or bring this complaint or appeal to:**

**Partnership HealthPlan of California  
360 Campus Lane, Ste., 100  
Fairfield, CA 94534  
Attn: Grievance Unit**

You may also make your complaint by telephone. Contact the Partnership HealthPlan of California's Member Services Department at (707) 863-4120 or 1-800-863-4155.