MEMBER GRIEVANCE FORM

Please Return:

Partnership HealthPlan of California

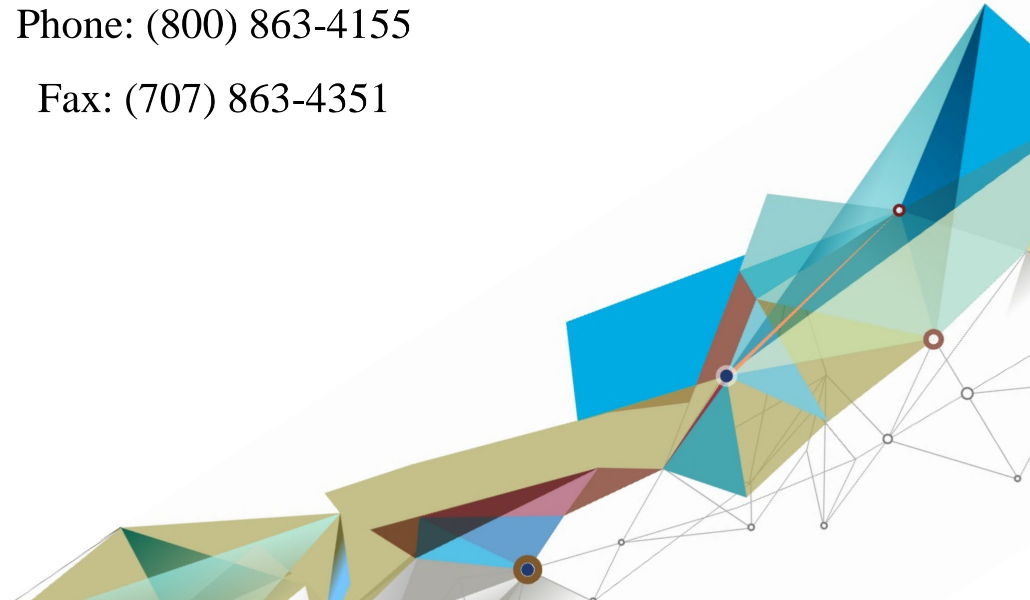
Attention: Grievance Unit

4665 Business Center Drive

Fairfield, CA 94534

Phone: (800) 863-4155

Fax: (707) 863-4351



Partnership HealthPlan of California's (PHC) has a grievance system to help you resolve problems with medical care and/ or services. The grievance system addresses how complaints and appeals are handled by PHC.

How to File a Complaint or an Appeal

There are two types of grievances; complaint and an appeal. You have the right to file a complaint or an appeal on any issue that is regarding your Medi-Cal benefit. Your grievance must explain your issue and why you disagree with a decision made by PHC, one of its providers, or if you are not happy with the service you received. Please note that PHC does not handle issues about your Medi-Cal eligibility. For eligibility issues contact your County Eligibility Worker.

Grievance Process

A grievance is an expression of dissatisfaction. Grievances can be filed by telephone, in writing, in person, filed through a contracted provider and through PHC website http:www.partnershiphp.org.

Processing your Grievance

PHC will send you an acknowledgment letter within five (5) calendar days of the date of receiving your grievance. You can contact the PHC grievance staff to discuss your grievance. PHC will send you a written resolution to your grievance within thirty (30) days from receiving your grievance. If you file an appeal, PHC will make every effort to resolve your appeal within thirty (30) calendar days. However, if there is some reason this is not possible, you will be notified by letter that additional time is required. PHC will then send you a written resolution within an addition fourteen (14) calendar days. If you are not satisfied with our resolution, you may request a State Hearing. Please note, you must file a grievance through PHC. You have the right to file a State Hearing if you disagree with the resolution made by PHC. You may file a State Hearing after receiving resolution from PHC.

Expedited Review Request

If you feel that a delay in processing your grievance through the standard timeframe would create a serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function, you can call PHC's Member Service Department at 800-863-4155 and request an expedited grievance.

Timeframes for Submission

You can file your complaint anytime following any incident or action in which you were dissatisfied. You must file an appeal within sixty (60) calendar days from the date of the notice of action.

To File a State Hearing

There are four ways to request a State Hearing. By telephone (800) 952-5253 TDD (800)-952-8349, by mail California State Department of Social Services State Hearing Division P.O. Box 944243 Mail Station 9-17-37 Sacramento, CA 94244-2430 by fax (916) 651-5210 or (916) 651-2789 or by filing in person at your local county office. For more information, please refer to your member handbook section 5.

Authorized Representative

Authorized representative forms are required for grievances filed for members over the age of 18.

Your Rights

To learn more about your rights and the grievance process, please call Member Services at (800) 863-4155.

Member Name: ____ Member ID: _________________________

Address: ____ City: _______________________________

Daytime Phone Number: ________________________ Alternative Phone Number: _____________________

Select one of the following grievance types that you would like to file: ☐ Complaint ☐Appeal

Complaints

Date of incident: _____________________________

Who was involved? ____

Where did the incident occur? ____

What was the issue(s)? ____

____

____

____

What action(s) did you take to resolve the issue(s)? ____

____

____

What would you consider a proper solution to the issue(s)? ____

____

____

Appeals

Date of the denial or modification: _____________________ TAR/TAR Auth#: ________________________

Name of the medication/service denied or modified: ____

Why do you feel that PHC was incorrect? ____

____

____

Member Signature: ____ Date: __________________________

Authorized Representative Section

Name of the person completing this form (if different from above) ____________________________________

Relationship: _____________________________ Contact telephone number: _________________________

Please note, a signed authorized representative form needs to be completed if one is not on file for members who are over the age of 18. Please complete the back of this form.

AUTHORIZATION TO RELEASE PATIENT HEALTHCARE INFORMATION

4665 Business Center Dr.
Fairfield, CA 94534
Fax: (707) 863-4415

Redding Regional Office
3688 Avtech Parkway
Redding, CA 96002
Fax: 530-223-2508

Member's Name: ______________________________ Date of Birth (mm/dd/year): ______________________

Previous Name: ________________________________ Member ID/CIN: _______________________________

I request and authorize ____to release health care information of the patient named above to:

Name: ____ Phone: __________________________

Address: ____

City: ______________________________________ State: ______________ Zip Code: ____________________

METHOD OF RELEASE (CHECK ALL THAT APPLY)

☐ Telephone/Verbal (Telephone#) ___________________________________ ☐ U.S. Mail/In person

☐ Fax#: ______________________________________

THIS REQUEST AND AUTHORIZATION APPLIES TO: (INITIAL IF APPLICABLE)

_____ Copies of records or medical information within the following dates: ______________ to ____________

_____ All healthcare information (except protected records)

_____ Records limited to a specific medical provider: ____

_____ Healthcare information relating to a specific treatment or condition: ______________________________

_____ Assistance with pharmaceutical and medical issues

_____ Authorization to make Primary Care Provider changes

_____ Other: ____

SPECIAL AUTHORIZATION FOR RELEASE OF PROTECTED RECORDS

The following information will not be released unless you authorize it by initialing next to the item below (for definitions for each of these items, see page three of this document):

_____ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42C.F.R. §§2.34 and 2.35).

_____ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et seq.)

_____ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).

EXPIRATION OF AUTHORIZATION (INITIAL IF APPLICABLE)

_____ Unless otherwise revoked, this Authorization expires (insert date).

_____ This authorization is valid until the member notifies PHC of the termination.

_____ If no date is indicated, the Authorization will expire 90 days after the date of signing this form.

______________________________	______________________________
Print Name	Signature (Member, Parent, Guardian)
______________________________	______________________________
Date	Relationship to Member (Parent, Guardian, Conservator, Member Representative)

NOTICE

Partnership HealthPlan of California and other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases:
(1) To conduct research-related treatment
(2) To obtain information in connection with eligibility or enrollment in a health plan
(3) To determine an entity's obligation to pay a claim
(4) To create health information to provide to a third party

This Authorization may be withdrawn and revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to:

Partnership HealthPlan of California (PHC)
c/o Member Services Department
4665 Business Center Drive
Fairfield, CA 94534
Fax: (707) 863-4415

Partnership HealthPlan of California (PHC)
c/o Member Services Department
3688 Avtech Parkway
Redding, CA 96002
Fax: 530-223-2508

The revocation will take effect when PHC receives it. However, your withdrawal/revocation will not affect the rights of anyone acting in reliance of this consent prior to notice of the withdrawal/revocation.

You are entitled to receive a copy of this Authorization.

DEFINITIONS

Sexually Transmitted Disease (STD) as defined by Title, 17 CCR § 2500 includes Chancroid, Lymphogranuloma venereum, Granuloma Inguinale, Syphilis, Gonorrhea, Chlamydia, Pelvic Inflammatory Disease, and Nongonococcal Urethritis.

HIV/AIDS as defined by Health and Safety Code § 120775, "AIDS" means acquired immune deficiency syndrome. HIV means Human immunodeficiency virus or the etiologic virus of AIDS.

Drug or alcohol treatment as defined by Title, 22 CCR § 51341.1 includes narcotic treatment program services, outpatient drug free treatment, group counseling sessions, individual counseling, day care habilitative services, perinatal residential substance use disorder services, and naltrexone treatment services.

Mental Health treatment as defined by Title 9 CCR § 1830.205 includes Pervasive Development Disorder, Disruptive Behavior and Attention Deficit Disorders, Feeding and Eating Disorders, Elimination Disorders, Schizophrenia and other Psychotic Disorders, Mood Disorders, Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Paraphilias, Gender Identity Disorder, Impulse Control Disorders, Personality Disorders, Medication-Induced Movement Disorders.