GRIEVANCE FORM

GEOGRAPHIC MANAGED CARE	COMMERCIAL MANAGED CARE	LOS ANGELES PREPAID HEALTH PROGRAM
❑ GMC	❑ DHMO	❑ LAPHP

Access Dental / Premier Access ("The "Plan") takes very seriously problems raised by its enrollees and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact any Plan Member Services Representative at 1-800-707-6453 or any Plan provider representative.

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____ Telephone: (_____) _____- _____

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & USE THE BACK OF THIS FORM IF MORE SPACE IS NEEDED):

_____

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_____

DATE OF INCIDENT GIVING RISE TO THIS COMPLAINT: _____

NAMES OF PLAN PERSONNEL INVOLVED IN INCIDENT: _____

_____

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 **(1-800-707-6453)**, 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-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 online.

PLEASE MAIL THIS FORM TO:

Grievance Department
Access Dental / Premier Access
P. O. Box: 255039
Sacramento, CA 95865-5039

Please do not write below this line – for Plan use only.

Name of Person Taking Complaint:_____	Date Received:_____	Time Received:_____	Date/Time Logged:_____