IEHP DualChoice (HMO D-SNP) **Appeal & Grievance Form**

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. IEHP DualChoice **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call IEHP DualChoice Member Services at **1-877-273-IEHP (4347)** or **1-800-718-4347 (TTY),** from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays. IEHP's DualChoice Member Services contact information may also be found on your IEHP DualChoice card. As a Member of IEHP DualChoice, you have the right to file a complaint against IEHP DualChoice or its providers without fear of negative action by IEHP DualChoice, your doctor, or any other provider.

Please print or type the following information:

Member Name (Last, First, Middle Initial) ____________ IEHP I.D. CARD Number ____________

Member Address ____________ Home Phone Number ____________

City, State, Zip ____________ Work or Message Phone Number ____________

Medicare Number ____________ Male/Female ______ Date of Birth ____________

Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:

Name: ____________ Telephone: ____________

Relationship to Member: ____________

Address: ____________

City: ____________ State: ______ Zip: ______

Nature of complaint:

WHERE DID THE INCIDENT HAPPEN? *(NAME OF HOSPITAL, DOCTOR, OR OTHER LOCATION)*

____

WHEN DID THIS HAPPEN? *(IF UNSURE, GIVE APPROXIMATE DATE(S)/TIME(S))*

____

WHO WAS INVOLVED?

____

PLEASE DESCRIBE WHAT HAPPENED. *(ATTACH COPIES OF ANY ADDITIONAL INFORMATION, IF NECESSARY)*

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Please sign and MAIL OR FAX THIS FORM TO: IEHP DUALCHOICE
Attn: Appeal and Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax**: (909) 890-5748**; For Questions Call **1-877-273-IEHP (4347)** or **1-800-718-4347 TTY**, from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

Date____________ **Member Signature**____________

Date____________ **Signature of Representative** ____________

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You may have the right to appeal.

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at **1-877-273-IEHP (4347)** to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/ TDD **1-800-718-4347**, from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call your plan or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can File:

Standard (30 days) - You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal

Fast (72-hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.

If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service.

Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to your health plan at the address indicated on the California Medicare Advantage Plan Member Appeal & Grievance Form.

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax using the plan contact information indicated on the California Medicare Advantage Plan Member Appeal & Grievance Form.

What Happens Next? If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare Advantage Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens**.**

Other Contact Information:

If you need information or help, call us at:

Toll Free: **1-877-273-IEHP (4347)**

TTY: **1-800-718-4347**

From 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

Other Resources To Help You:

Medicare Rights Center Toll Free: **1-888-HMO-9050**

Elder Care Locator: Toll Free: **1-800-677-1116**

1-800-MEDICARE (1-800-633-4227) TTY/TTD: **1-877-486-2048**

24 hours a day, 7 days a week

IEHP DualChoice (HMO D-SNP) is an HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.