VENTURA COUNTY
HEALTH CARE PLAN
A Department of Ventura County Health Care Agency

Cancellation of Health Care Coverage Grievance Form

Name: _____

(Full name of enrollee, subscriber, or group contract holder filing this grievance)

Name and Identification number(s) of all enrollees affected:

Name:_____ Member ID Number: _____

Name:_____ Member ID Number: _____

Name:_____ Member ID Number: _____

Name:_____ Member ID Number: _____

Name of parent or guardian, if filing for minor enrollee: _____

Date of birth: _____ **Gender:** ☐Male ☐Female ☐Other:_____

Mailing address: _____ _____ _____ _____
(Street address) (City) (State) (Zip)

Daytime phone number: (____)_____ **Evening phone number:** (____)_____

Email address: _____

Employer, if applicable: _____

Health plan name: _____

Health plan membership number: _____

Medical group name, if applicable: _____

Medi-Cal identification number, if applicable: _____

Medicare or Medicare Advantage identification number, if applicable: _____

Date enrollee received notice that coverage was or will end: _____

Date enrollee filed a grievance with an entity other than the DMHC, if applicable: _____

Please attach the following:

- Copies of proof of payment for the last paid coverage period.
- Copies of VCHCP notice(s) and correspondence(s) received, if any.
- Copies of enrollee correspondence(s) sent, if any.

Explanation of reason for filing the grievance:

Signature of enrollee: _____ **Date:** _____

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with VCHCP and/or the Department of Managed Health Care. Although you are not required to utilize it, this form is available for your convenience and should be mailed to the address provided in the Grievance/Complaint Form Instruction Sheet section below.

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 (**1-805-981-5050**) or (**1-800-600-8247**) and for hearing impaired members: TDD to Voice (**1-800-735-2929**); Voice to TDD (**1-800-735-2922**) for English or (**1-800-855-3000**) for Spanish 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR VCHCP ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with VCHCP and/or the Department of Managed Health Care.

OPTION (1) - YOU MAY SUBMIT A GRIEVANCE TO VCHCP.

- You may submit a grievance to VCHCP by calling (805) 981-5050 or (800) 600-8247, online at vchcp.venturacounty.gov, or by mailing your written grievance to Ventura County Health Care Plan at 2220 E. Gonzales Road, Suite 210-B; Oxnard, CA 93036.
- You may want to submit your grievance to VCHCP first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- VCHCP will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from VCHCP within three (3) calendar days, or if you are not satisfied in any way with VCHCP's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a grievance to the Department of Managed Health Care without first submitting it to VCHCP or after you have received VCHCP's decision on your grievance.
- You may submit a grievance to the Department of Managed Health Care online at:

  WWW.HEALTHHELP.CA.GOV

- You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

  HELP CENTER
  DEPARTMENT OF MANAGED HEALTH CARE
  980 NINTH STREET, SUITE 500
  SACRAMENTO, CALIFORNIA 95814-2725

- You may contact the Department of Managed Health Care for more information on filing a grievance at:

  PHONE: 1-888-466-2219
  TDD: 1-877-688-9891
  FAX: 1-916-255-5241

GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET

If you have questions, call the Help Center at 1(888) 466-2219 or TDD at 1(877) 688-9891. This call is free.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]
   OR
   Fill out and sign the Cancellation of Health Care Coverage Grievance Form.
2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from VCHCP, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:

   DEPARTMENT OF MANAGED HEALTH CARE
   HELP CENTER
   980 9TH STREET, SUITE 500
   SACRAMENTO, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

MEDICAL RELEASE

I request that the Department of Managed Health Care (DMHC) make a decision about my problem with my plan. I request that the DMHC review my Cancellation of Health Coverage Grievance Form to determine if my grievance qualifies for the DMHC's Consumer Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my grievance. These records may also include non-medical records and any other information related to my grievance. I allow the DMHC to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Enrollee, Legal Guardian, or Parent Signature: _____

Date: _____

Please see the instruction sheet for mailing or faxing information.

AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your grievance, complete Parts A and B below.

If you are a parent or legal guardian submitting this grievance for a child under the age of 18, you do not need to complete this form.

If you are filing this grievance for an enrollee who cannot complete this form because the enrollee is either incompetent or incapacitated, and you have legal authority to act for this enrollee, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the enrollee.

PART A: ENROLLEE

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my grievance will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Enrollee Signature: _____ Date: _____

PART B: PERSON ASSISTING ENROLLEE

Name of Person Assisting (print): _____

Signature of Person Assisting: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Enrollee: _____

Daytime Phone #: _____ Evening Phone #: _____

Email Address (if available): _____

My power of attorney for health care decisions or other legal document is attached: ☐(check if applicable)

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with VCHCP.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with VCHCP and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.