P. O. Box 2756
Mission Viejo, CA 92690
1-888-439-3392
TDD 1-949-364-1289
www.eyexamofca.com

GRIEVANCE FORM FOR CANCELLATIONS, RESCISSIONS AND NONRENEWALS

Enrollee Information

First Name_____Middle Initial_____Last Name_____

Enrollee's Date of Birth (mm/dd/yyyy)_____ Gender Male ☐ Female ☐ Other ☐

Name of Parent or Guardian if Filing for Minor Child_____

Street Address_____

City_____State_____Zip_____

Daytime Phone #_____Evening Phone #_____

Email address_____

Health Plan Name_____Membership #_____

Medical Group Name(if enrolled in medical group)_____

Employer_____Not Employed ☐

Date enrollee received notice that coverage was or will end_____Date enrollee filed a grievance with EYEXAM of California, Inc. (EECA)_____

Date enrollee filed a grievance with an entity other than the Department, if applicable_____

Please provide to EECA the following: 1) copies of EYEXAM notice(s) and correspondence(s) received, if any 2) copies of enrollee correspondence(s) sent, if any 3) copies of proof of payment for the last paid coverage period and 4) completed and signed medical release below

Do you want someone to help you with your complaint? ☐ Yes ☐ No

If yes, please complete the attached "Authorized Assistant Form."

Have you filed a complaint or grievance with EYEXAM of California? ☐ Yes ☐ No

Are you seeking payment for a service you have already received? ☐ Yes ☐ No

If yes, list the date(s) of service, and the provider's name:

_____

Are you seeking authorization for future services? ☐ Yes ☐ No

Do you need help with daily activities or consider yourself to have a disability? ☐ Yes ☐ No

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Briefly explain your reason for filing the grievance.

Enrollee, Legal Guardian or Parent Signature_____Date_____

Medical Release

I request that the Department of Managed Health Care (DMHC) make a decision about my problem with EYEXAM. 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. By signing and dating below, I authorize my providers, past and present, 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 authorize the DMHC to review these records and information and send them to EYEXAM. 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 by sending a written request. All the information that I have provided on this sheet is true.

Enrollee, Legal Guardian or Parent Signature_____Date_____

Please see the instruction sheet attached for mailing or faxing information.

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION OR NONRENEWAL OF YOUR PLAN 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 the Plan and/or Department of Managed Health Care (DMHC or Department).

OPTION (1)- YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN

You may submit a grievance to EYEXAM of California, Inc. (EYEXAM or Plan) by calling 1-888-439-3392, online at www.eyexamofca.com, or by mailing your written grievance, by using the form above and mailing it to P.O. Box 2756, Mission Viejo, CA 92690. You may want to submit your grievance to EYEXAM first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible. EYEXAM will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from the Plan within three (3) calendar days, or if you are not satisfied in any way with the Plan's response, you may submit a grievance to the Department 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 without first submitting it to the Plan or after you have received the Plan's decision on your grievance. You may submit a grievance to the DMHC online at the internet website: http://www.dmhc.ca.gov. You may submit a grievance to the DMHC by mailing your grievance to: HELP CENTER DEPARMENT OF MANAGED HEALTH CARE, 980 NINTH STREET, SUITE 500, SACRAMENTO, CALIFORNIA 95814-2725. You may contact the DMHC for more information on filing a grievance at: PHONE 1-888-466-2219, TDD: 1-877-688-9891, and/or FAX: 1-916-255-5241.

AUTHORIZED ASSISTANT FORM

- **If you want to give another person permission to assist you with your grievance, please 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 member 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 authorize the person named below in Part B to assist me in my grievance filed with Department of Managed Health Care (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_____

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.

Grievance/Complaint Form Instruction Sheet

If you have questions on completing this form, please call the Department of Managed Health Care's Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is toll free.

How to File:

1) File on the Department's internet website at http://www.dmhc.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 your health plan, 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?

Patient Relations 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.

If it is determined that your complaint should be reviewed through the Grievance Process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

The Information Practice 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 complaints of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- 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 the Plan and your providers to help investigate your grievance.
- The DMHC may also share your personal 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

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 **(888) 439-3392** and use your health plan's grievance process before contacting the department. The Plan also has a TDD **(949) 364-1289** for the hearing impaired. 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 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.

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