California Dental Network, Inc.

23291 Mill Creek Drive, Suite 100, Laguna Hills, CA 92653

Cancellation of Healthcare Coverage Grievance Form

MEMBER INFORMATION

Member Name: _____ Gender: [] Male [] Female [] Other

Parent/Guardian Name *(if completed for a minor child)*: _____

Member Date of Birth: _____ Membership#: _____

Member Mailing Address: _____

Member City, State, Zip: _____

Day Phone: (_____) _____ Evening Phone: (____) _____

E-Mail Address: _____

Employer (if Applicable): _____

Name(s) of All Enrollees Effected: _____

_____

Subscriber Identification #(s) of All Enrollees Effected): _____

_____

Health Plan Name: _____

Medi-Cal identification # (if applicable): _____

Medicare or Medicare Advantage ID # (if applicable): _____

Medical Group (if Applicable): _____

Member Signature: _____ Date: _____

GRIEVANCE INFORMATION

If Applicable:

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

Date Member filed a grievance with an entity other than the DMHC: _____

If Available, Please Provide:

Copies of plan notice(s) and correspondence(s) received, if any
Copies of any correspondence(s) sent by the Member
Copies of proof of payment for the last paid coverage period

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..

Member, Legal Guardian, or Parent Signature:_____ Date:_____

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 **1-714-479-0777 or toll-free 1-877-4-DENTAL** 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 Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

DESCRIBE THE INCIDENT AND YOUR GRIEVANCE *(ATTACH ADDITIONAL PAGES, IF NEEDED)*

(Attach Additional Sheets As Needed)

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: MEMBER

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.

*Member Name (Print)*_____

*Member Signature*_____ *Date*_____

PART B: PERSON ASSISTING MEMBER

Name of Person Assisting (print) _____

*Signature of Person Assisting*_____

Street Address _____

City: _____ *State:*_____ *Zip:*_____

Relationship to Patient _____

Daytime Phone # _____

Evening Phone # _____

*Email Address:*_____

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

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.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?

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.

THIS NOTICE IS REQUIRED BY LAW

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 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 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.