

Inland Empire Health Plan  
 Attn: Grievance Department  
 P.O. Box 19026  
 San Bernardino, CA 92423-9026  
 Fax # (909) 890-5748



INLAND EMPIRE HEALTH PLAN

For Questions Call  
 1-800-440-4347 or  
 TTY 1-800-718-4347

**MEMBER COMPLAINT FORM**

**Please complete the following form and return it to IEHP Grievance Department at the address above.**

**MEMBER INFORMATION**

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY # - -
MEMBER ADDRESS:			IEHP MEMBER ID #
			TELEPHONE # ( ) -

**PERSON MAKING THE COMPLAINT** (You have the right to appoint someone to file your grievance or represent you during the grievance process. In addition, grievances can be filed by parents, guardians, conservator, relative or other designee, if the Member is a minor or an adult who is incapacitated)

NAME _____
RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER _____

**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))
WHO WAS INVOLVED?
PLEASE DESCRIBE WHAT HAPPENED. (ATTACH ADDITIONAL PAGES, IF NECESSARY)

As a Member of IEHP, you have the right to file a complaint against IEHP or its providers without fear of negative action by IEHP, your Doctor, or any other provider. You also have the right to request a Medi-Cal fair hearing at any time during the grievance process and/or make a complaint/grievance to the Department of Managed Health Care, which regulates health plans. If you have any questions, please call 1-800-440-4347, or 1-800-718-4347 (TTY).

MEMBER'S SIGNATURE _____	DATE _____
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SIGNATURE OF PARENT OR LEGAL GUARDIAN (IF THE MEMBER IS A MINOR OR INCOMPETENT) _____	DATE _____
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### **Notice of Right To Medi-Cal Fair Hearing:**

IEHP Members have a right to request a Medi-Cal Fair Hearing at any time during the complaint/grievance process, regardless of whether a complaint/grievance has been submitted or within 90 days from the date of the occurrence that caused you to express dissatisfaction. Members may call the Department of Social Services Public Inquiry and Response Unit at **(800) 952-5253**, to request a Fair Hearing. For the hearing impaired: **(800) 952-8349**. Members may also request a Fair Hearing by mail at the following address: California Department of Social Services, State Hearing Division, P.O. Box 944243, Mail Station 19-37, Sacramento, CA 94244-2430.

**Authorized Representative:** You can represent yourself at the State Medi-Cal Fair Hearing. If you choose, a friend, an attorney, or any other person may represent you, but you must arrange this yourself. The Public Inquiry and Response Unit at **(800) 952-5253** can help you find free legal help.

### **Department of Managed Health Care:**

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 **1-800-440-4347**, or **1-800-718-4347 TTY** 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.

The above services are available to IEHP Member's at no cost.