Member Grievance Form

There are two sides to this form.
Please print clearly.
Complete all sections of this form.

CIGNA HealthCare of California, Inc.

MAIL TO: National Appeals Unit
P.O. Box 5225
Scranton, PA 18505-5225
Member Services: 1.800.244.6224 Toll Free
1.800.321.9545 (TTY)

OR FAX: 1.866.254.9406 Toll Free

I am submitting a grievance to CIGNA HealthCare of California, Inc. ("CIGNA HealthCare")

IN AN EMERGENCY, PLEASE CALL 911 OR GO DIRECTLY TO THE NEAREST EMERGENCY ROOM.

☐ **Check this box if this case involves an imminent and serious threat to you or the health of the patient, including but not limited to, severe pain, the potential loss of life, limb or major bodily function. If it does, please phone CIGNA HealthCare Member Services at 1-800-244-6224 (1-800-321-9545 (TTY) for the hearing and speech impaired) or the toll free number on your CIGNA HealthCare Identification Card.**

Please read the attached brochure about your right to file grievances with CIGNA HealthCare. To serve you quickly, it is important that you provide as much information as possible. If you have any questions about the meaning of anything on this Form, please call Member Services at 1-800-244-6224 or the toll free telephone number on your CIGNA HealthCare Identification Card.

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 **1-800-244-6224 or the toll-free telephone number on your CIGNA identification card (1-800-321-9545 (TTY) for the hearing and speech impaired)** 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.

MEMBER INFORMATION *(Member complete this information)*

Name *(Last)* *(First)* *(Middle Initial)*	Member Identification Number

Mailing Address *(Street)*	*(City)*	*(State)*	*(Zip Code)*

Daytime Telephone Number	Evening Telephone Number
( )	( )

Name of Person filing Grievance *(if other than member)*

PATIENT INFORMATION *(Complete only if patient is other than member)*

Name *(Last)* *(First)* *(Middle Initial)*	Relationship to Member	Member Identification Number

Mailing Address *(Street)*	*(City)*	*(State)*	*(Zip Code)*

Daytime Telephone Number	Evening Telephone Number
( )	( )

(Continued on Reverse Side)

MEMBER GRIEVANCE INFORMATION

List name, phone number and address of the physician or medical group this grievance is about.

Name of Physician or Medical Group	Telephone Number ( )

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Briefly outline the specific details of your grievance. Identify what the grievance is, and WHEN the events you describe took place. If helpful, please provide COPIES of all itemized bills, checks (both sides) and correspondence related to this grievance.

If this grievance involves a denial for treatment, services or supplies deemed to be experimental for a terminal illness and you would like to request a conference as part of the grievance system, please let us know below.

Attach additional pages to this form, if needed.

Have you sent any records, correspondence, or other concerns about this case to CIGNA HealthCare Member Services or any one else connected with CIGNA HealthCare? ☐ Yes ☐ No

If yes, please list below when you sent it and to whom. Please include their phone or facsimile number if you know it.

CIGNA HealthCare Contact	Telephone or Facsimile Number ( )

Date(s)

CERTIFICATION

I certify that this information is true and correct.

Member/Patient Signature	Date

WHEN COMPLETED, MAIL THIS FORM TO: CIGNA HealthCare of California, Inc.
National Appeals Unit
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OR, FAX IT TO: 866-254-9406 Toll Free

FOR INTERNAL USE ONLY:

☐ Initial Determination ☐ Complaint ☐ Appeal