SECTION	Approval date:	
Office Management	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Member Grievances/Complaints	Revision date:	

POLICY:

The site has an established process for member grievances and complaints.

DEFINITION:

A "grievance" is defined as any written or oral expression of dissatisfaction that involves coverage dispute, healthcare medical necessity, experimental or investigational treatment. The health plan does not delegate the resolution of grievances to contracted medical groups.

A "complaint" is any expression of dissatisfaction regarding the quality of service (excluding quality of care) which can be resolved in the initial contact. A "complaint" is self-limiting (e.g., service complaints, appointment wait times) that can be resolved to the member's satisfaction, such as they do not ask for additional assistance

PROCEDURE:

A. The staff shall ensure that any member who expresses a grievance or complaint is informed of the right for a State Fair Hearing and offered the following numbers:

- The California Department of managed health Care: 1-888-HMO-2219
- For Hearing and Speech impaired persons call: 1-800-735-2929
- State Fair Hearing: 1-800-952-5253

B. Staff shall ensure that grievance forms (in threshold languages) for each participating health plan shall be provided to members promptly upon request.
- The grievance form must be submitted to the health plan within one (1) business day

C. The staff shall ensure that all complaints (e.g., service complaints, appointment wait times) are tracked and submitted to the health plan after each occurrence.

- These complaints may be resolved at the point of service
- Log the complaint to include the following information:
    a. Date of complaint
    b. Name of complainant and ID#
    c. Nature of the complaint
    d. Resolution/action taken (include information communicated to health plan, as appropriate)
    e. Date of resolution/action
    f. Date log submitted to health plan