

## INDEPENDENT MEDICAL REVIEW APPLICATION (IMR)/COMPLAINT FORM

### IMPORTANT INFORMATION

**You can submit your IMR Application/Complaint Form online at: [www.HealthHelp.ca.gov](http://www.HealthHelp.ca.gov)**

- ❖ **FREE:** The IMR/Consumer Complaint process is free.
- ❖ **FAST:** IMRs are usually decided within 30 days, or within 7 days if the health issue is urgent.
- ❖ **SUCCESSFUL:** Close to **60%** of patients receive the requested service through IMR.
- ❖ **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

### PATIENT INFORMATION

First Name \_\_\_\_\_ Middle Initial\_\_ Last Name\_\_\_\_\_

Patient's Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Gender: Male  Female

Name of Parent or Guardian if Filing for Minor Child \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

Health Plan Name \_\_\_\_\_ Patient's Membership # \_\_\_\_\_

Medical Group Name (if enrolled in a medical group) \_\_\_\_\_

Employer \_\_\_\_\_ Not Employed

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

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

Do you have Medi-Cal?  Yes  No

If yes, have you filed a Request for a State Fair Hearing?  Yes  No

Do you have Medicare or Medicare Advantage?  Yes  No

Have you filed a complaint or grievance with your health plan?  Yes  No

Are you seeking payment for a service that 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

# INDEPENDENT MEDICAL REVIEW APPLICATION/COMPLAINT FORM

## **YOUR HEALTH PROBLEM** (Use a separate sheet and attach other documents, if needed.)

What is your medical condition or doctor's diagnosis? (please be specific) \_\_\_\_\_

What medical treatment(s)/service(s) and/or medication(s) are you requesting? (please be specific)

\_\_\_\_\_

Did your plan say that the treatment you want is (check one):

- Not Medically Necessary  
 Not an Emergency/Urgent

- Experimental or Investigational  
 Other (please explain below)

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

\_\_\_\_\_

Have you seen any out-of-network providers for your condition?

Yes  No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid claim, trouble getting an appointment or medication, or if your coverage has been cancelled by the plan.

## **MEDICAL RELEASE**

I request the Department of Managed Health Care (DMHC) to make a decision about my problem with my plan. I request the DMHC to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or 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 case. These records may also include non-medical records and any other information related to my case. 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.

Patient or Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Please see the instruction sheet for mailing or faxing information.

### *FOR STATISTICAL INFORMATION ONLY*

You are asked to voluntarily provide the following information. Giving this information will help the DMHC identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the DMHC to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken: \_\_\_\_\_

Choose not to provide

Race/Ethnicity Heritage: \_\_\_\_\_

Choose not to provide

# AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.

If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.

If you are filing this IMR/Complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, 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 patient.

## PART A: PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (DMHC). I allow the DMHC and IMR 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 IMR or complaint 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.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## PART B: PERSON ASSISTING PATIENT

Name of Person Assisting (print) \_\_\_\_\_

Signature of Person Assisting \_\_\_\_\_

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.

## IMR Application/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.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The DMHC may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DMHC for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

### How to File:

1) File online at [www.HealthHelp.ca.gov](http://www.HealthHelp.ca.gov). **This is the fastest way.**

or

Fill out and sign the enclosed IMR Application/Complaint Form. Use the envelope provided with the form.

2) If you want someone to help you with your IMR or complaint, complete the "Authorized Assistant Form".

3) If you have medical records from **out of network providers**, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.

4) You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The DMHC will obtain this information directly from your plan as part of the investigation.

5) If you are not submitting online, please mail or fax your form and any supporting documents to:

DMHC 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 within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center's possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

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

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 complaints of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- 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 complaint or provide an IMR.
- The DMHC may share your personal information, as needed, with the plan and providers who conduct the IMR.
- 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.