FILING A GRIEVANCE

Western Health Advantage

advantage you

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Western Health Advantage's goal is to provide its members with the optimum quality and member service experience. To this end, WHA has established a formal process for addressing member concerns, complaints, grievances and appeals.

What is a Grievance?

A grievance is any written or oral expression of dissatisfaction made by you, your representative or your provider regarding your experience with WHA, your medical group or any WHA participating provider.

A "standard" or routine grievance is usually investigated and resolved within 30 calendar days. A "fast track" or expedited grievance is completed within 72 hours from receipt of the formal complaint.

What is an Appeal?

An appeal is a verbal or written formal request to re-review or reconsider a decision that has been made. The appeal can be related to a payment issue, an administrative action, quality of care or service issue or utilization recommendation. Your appeal will be reviewed by a doctor who was not involved in the initial review of the issue. This doctor will make an independent second decision after reviewing all available information. The second decision may agree or disagree with the first decision.

Standard or routine appeals are completed within 30 calendar days. A delay in a final decision may occur if additional information is needed for the reviewer to make an informed decision. Expedited or "fast track" appeals are completed within 72 hours upon request if delaying the appeal decision risks jeopardizing your health. You have the right to request a "fast track" or expedited appeal if your doctor agrees there are health risks in delaying the decision. WHA's Medical Director will make the decision as to whether the appeal will be handled as an expedited or standard appeal.

What is WHA's Grievance and Appeal Procedure?

If you have a complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other complaint, please call Member Services for immediate assistance.

If your complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written grievance or appeal may be submitted to:

Mail:	Western Health Advantage Attn: Member Relations 2349 Gateway Oaks, Suite 100 Sacramento, CA 95833
Secure fax:	916.563.2207
Call:	916.563.2250 or 888.563.2250 888.877.5378 TDD/TTY
Email:	appeal.grievance@westernhealth.com
Online form:	mywha.org/grievance

Please complete the attached form. Be sure to include a discussion of your questions or situation and your reasons for dissatisfaction. Submit the grievance or appeal to WHA Member Services, Grievances and Appeals Department within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the appeal is being decided.

If you believe that your membership has been or will be improperly canceled, rescinded or not renewed, you may request a review by WHA or go directly to the Department of Managed Health Care. If your coverage is still in effect when you submit your grievance, your coverage will be continued while your grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the grievance, including any appeal to the California Department of Managed Health Care, if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All premiums must be up to date and paid timely.

WHA will send an acknowledgment letter to you within five (5) calendar days of receipt of your grievance or appeal. A determination is rendered within thirty (30) calendar days. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the grievance or appeal will be provided to the Member and will include an explanation of the contractual or clinical rationale for the decision.

A grievance form and a description of the grievance procedures are available at every Medical Group and Plan facility. In addition, a grievance form will be promptly mailed to you if you request one by calling Member Services. If you would like assistance in filing a grievance or an appeal, please call Member Services and a representative will assist you in completing the form or explain how to write your letter. We will also be happy to take the information over the phone verbally or through a secure message on myWHA.

For detailed information about the grievance and appeal procedure visit **mywha.org/grievance** or call WHA Member Services at 916.563.2250 or 888.563.2250.

Terminal Illness Conference

If WHA has denied treatment, services or supplies deemed experimental and you have a terminal illness (a condition that has a high probability of causing death within one year or less), you can request a conference as part of the grievance system. Please indicate on the grievance form your request for a conference.

Plan Partner Grievances

If you have a grievance about your dental, vision or mental health services, visit **mywha.org/grievance** for special instructions.

Language Assistance

WHA wants to ensure all Members have access to the grievance and appeal system. WHA provides free-of-charge verbal and written translation services to those with limited English proficiency or with visual or other communicative impairments. Please contact WHA's Member Services Department for more information or visit **mywha.org/grievance** for more information.

GRIEVANCE/APPEAL REQUEST FORM

Mail to: Western Health Advantage, Attn: Member Relations
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.563.2207
Email to: appeal.grievance@westernhealth.com
Questions 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY
This form is also available online mywha.org/grievance

Member Name_____ Member ID Number_____ Birth Date_____

Street Address_____ City, State, Zip Code_____

Daytime Telephone Number_____ Okay to Leave Message ❑ Yes ❑ No

Alternate Telephone Number_____ Okay to Leave Message ❑ Yes ❑ No

Name of Person Filing _____
(If Different Than Above, Please Complete the Attached Authorized Assistance Form)

Relationship_____ Daytime Telephone Number_____

Department/Location or Medical Facility Where Issue Occurred_____

Date(s) Issue(s) Occurred_____

Please Describe the Nature of the Issue(s) — Attach Additional Sheets if Needed

_____

_____

_____

Please Explain How You Have Tried to Resolve the Issue(s)

_____

_____

_____

What Would You Consider a Proper Solution to the Issue(s)?

_____

_____

_____

Signature_____ Date_____

❑ Check Here If You Are Requesting A Terminal Illness Conference

For Internal Use Only: Member Services Representative Name_____ Date Received_____

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 **1-888-563-2250 (TTY/TDD 1-888-877-5378)** and use your health plan's grievance process before contacting the department. If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance. 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 website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

Authorization For Use or Disclosure of Health Information

Mail to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0126
Email to: memberservices@westernhealth.com
Include in Subject Line: Authorization for Use or Disclosure
Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY

A. Use this form to authorize Western Health Advantage ("WHA") to use or to disclose your health information to another person or organization.

1. Member whose information is to be disclosed

Name: _____

Address: _____

Member ID Number: _____ Date of Birth: _____

2. Person (the "Recipient") authorized to receive the Member's information

Recipient's Name: _____ Relationship to Member: _____

Recipient's Address: _____

3. Information to be disclosed to the Recipient (check only one of the three options)

❑ **All information** that WHA maintains, excluding Sensitive Information unless specifically authorized in section 4.

OR ❑ **Only the following information**, or types of information, WHA maintains: (check all that apply)

- ❑ Medical Information (diagnosis, treatment, medication, including authorizations and referral status)
- ❑ Health Plan Coverage and Eligibility
- ❑ Financial/Billing Information (e.g. Premium payments), excluding claims information
- ❑ Claims Status/Payment Information
- ❑ Other _____

OR ❑ Psychotherapy notes

If you check this box, you may not check any of the other boxes in this section or in section 4. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information; a separate form must be used.

4. Is the Recipient also authorized to receive Sensitive Information as described below?

❑ NO ❑ YES If Yes, I specifically authorize WHA to release to Recipient:

❑ **All sensitive information** OR ❑ **Only the following information:** (check all that apply)

- ❑ Alcohol/substance abuse ❑ Mental health ❑ Genetic information
- ❑ Sexually transmitted illness (including HIV/AIDS)
- ❑ Sexual, physical, or mental abuse
- ❑ Abortion/reproductive health (including pregnancy, contraception)

5. Reason for this authorization (check only one)

❑ Personal Use ❑ Legal ❑ Other (please specify): _____

6. Authorization to Act on Member's Behalf

I authorize the Recipient to perform the following acts:

- ❑ Enroll me/disenroll in/from Plan
- ❑ Choose/change my PCP
- ❑ Request new ID Card
- ❑ Change/correct missing/erroneous demographic information
- ❑ All of the above

B. Expiration

This authorization will remain in effect:

❑ for one (1) year from the date of your signature below, OR

❑ until Month _____ Day _____ Year_____ (this period cannot be longer than 3 years from the date of signature below)

C. Notice to Member

- You can revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information WHA used or disclosed before receipt of the revocation request.
- WHA may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether you or your representative sign this authorization.
- If this authorization is on behalf of a minor,
  - o federal and state laws may prohibit WHA from acting on your request about Sensitive Information without written authorization from the minor 12 years of age or older;
  - o it will expire when the minor turns 18 or is legally emancipated, or may be revoked by the legally capacitated minor.
- State law prohibits the re-disclosure of medical information by a Recipient without a separate authorization. If the requested information is re-disclosed, it may no longer be protected by federal privacy laws.
- If the requested information is Substance Abuse Information, this was disclosed from records protected by federal confidentiality rules. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- You are entitled to a copy of this form.
- If you send a completed form by email to WHA, you acknowledge that it is not best practice to send protected health information through email that is not secure.

D. Signature

I have read this form, and I understand and agree to its terms. I direct WHA to use or to disclose the information to the Recipient as directed above. I am signing this form of my own free will.

Signature_____ Date_____

Print Name_____

Relationship to Member (if applicable):_____

A copy of a photo ID of the person signing the form and of the Recipient, unless one is already on file with WHA, must be attached to this form.

Personal or legal representatives or guardians: If this form is signed by someone other than the Member or the parent of a minor, this authorization must be accompanied by documentary proof of the authority to act on behalf of the Member (or the Member's estate).

Keep a copy of this Authorization for your records.

WHA Internal Use Only

Date Request Received _____ ❑ Identification Verified (documents checked)

Signature of Manager or Supervisor _____

Printed Name _____