SHARP HEALTH PLAN

Member Grievance & Appeal Form

Purpose

The purpose of this form is to ask Sharp Health Plan to initiate the Grievance or Appeals process.

Instructions

1. You may file a Grievance or Appeal with Sharp Health Plan up to 180 calendar days following any incident that is subject to your dissatisfaction. Your request will be acknowledged within 5 calendar days of receipt, and resolved within 30 calendar days.
2. If you feel this request is urgent in nature, please contact customer care at 1-800-359-2002.

   Examples of urgent requests may include:

   - An imminent and serious threat to your health, including but not limited to, severe pain and /or potential loss of life, limb, or major bodily function.
   - A concern related to cancellation, rescission or nonrenewal of coverage.
3. Briefly outline the specific details of the problem and identify when the event(s) occurred.
4. Be sure to sign, date and include a Sharp Health Plan member ID number as well as date of birth.
5. Send this completed form and all relevant documents to Sharp Health Plan. Please keep copies of all items sent to Sharp Health Plan for your records.

   Examples of relevant documents may include:

   - Statements: Premium billing statement or Provider bills
   - Proof of payment: Receipts, a copy of the front and back of a canceled check, or credit card statement
   - Correspondence: plan notices or enrollee correspondence

Submit

Please submit the finished form by mail, in person, or fax:

By Mail or In Person:
Attention: Appeals & Grievances
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: Appeals & Grievances
619-740-8572

If you believe this case is urgent, call Sharp Health Plan immediately toll-free at 1-800-359-2002.

Patient Information

First name:		Last name:	Middle initial:
Member ID#:	Plan medical group:	Birth date: MM/DD/YY / /	Gender: ☐ Male ☐ Female ☐ Other
Email address:		Daytime phone number: ( )	Evening phone number: ( )
Home address:			
City:		State:	ZIP code:

Mailing address:		
City:	State:	ZIP code:

Subscriber Information (If subscriber is different than patient)

First name:	Last name:	Middle initial:
Employer:	Plan medical group:	Birth date: MM/DD/YY / /
ID#:	Daytime phone number: ( )	Evening phone number: ( )
Home address:		
City:	State:	ZIP code:
Mailing address:		
City:	State:	ZIP code:

Provider Information

Doctor or provider:	Phone number: ( )
Address:	

City:	State:	ZIP code:

Description of Concern

Briefly outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. Please include a statement regarding the outcome desired and what you believe the Plan can do to resolve your concern. If you have copies of documents, bills, checks, or other correspondence related to this problem that may help in the investigation and resolution, please include them with this form. If you need more pages to describe the issue, please attach them to this form.

Date enrollee received notice that coverage was or will end: (if applicable) / /	Are copies of enrollee correspondence with plan attached? (if applicable) ☐ Yes ☐ No
Are copies of proof of payment for the last paid coverage period attached? (if applicable) ☐ Yes ☐ No	Are copies of plan notices and correspondence received attached? (if applicable) ☐ Yes ☐ No

Subscriber name:	Subscriber signature: x	Date: / /
Parent / guardian name:	Parent / guardian signature: x	Date: / /

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 **1-800-359-2002** 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 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 Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

I authorize the below named person to act as my representative in the disposition of this grievance. I understand this authorization will automatically expire upon completion of the appeal or grievance filed on my behalf.

Patient signature: x	Date: / /
Authorized representative:	Relationship to patient:
Home address:	

City:	State:	ZIP code:

If you need assistance, we're here to help.

You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.
We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.