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 and 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
1-619-740-8572

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 Sharp Health 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 ending or will end (if applicable): / /	Are copies of enrollee correspondence with Sharp Health 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 website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

You have the right to submit grievances to the plan and the DMHC for the failure of Plan staff to provide trans-inclusive health care, which may include Plan services or health care services rendered by Plan providers. Trans-inclusive health care is defined in Section 1367.043(d)(3) as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

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:

Right to Request a Conference:

If you have a terminal illness and have been denied coverage for treatment, services, or supplies deemed experimental, you have the right to request a conference with representatives from Sharp Health Plan. At this conference you will have an opportunity to review the information provided to you by Sharp Health Plan regarding the denied services. You or your designee or both may attend the conference. If the member appealing the denial is a minor or incompetent, the parent, guardian, or conservator may attend the conference. Sharp Health Plan will provide you with an opportunity to attend a conference within thirty (30) calendar days of receipt of your request for a conference. The conference will be held within five (5) business days if the treating participating physician determines, after consultation with Sharp Health Plan's medical director, based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by Sharp Health Plan, would be materially reduced if not provided at the earliest possible date. Please check the box indicated below if you would like to request a conference to review your appeal.

☐ **I am requesting a conference to review my appeal with Sharp Health Plan representatives.**

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.