Member Grievance Form

Behavioral Solutions of California

If you are not satisfied with any aspect of your contact with OptumHealth Behavioral Solutions of California (OHBS-CA), also known as U.S. Behavioral Health Plan, California (USBHPC), or its representatives, please complete this form and return it to the address or fax number listed below.

Please provide the name, address, and phone number of the provider involved in the report, if applicable:

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_____

Please describe your grievance in as much detail as possible, including dates and names:

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Please complete the following information:

Member Name: _____ Member Date of Birth: _____

Member Address: _____

Contact Phone Number: _____

Subscriber Name: _____ Relationship to Subscriber: _____

If someone other than the member is completing this form, please include name, address, and relationship to the member: _____

_____

Date: _____

Please send the completed form by mail or fax to:

OptumHealth Behavioral Solutions of California
Attn: Grievances and Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470

You may also file your appeal online by visiting www.liveandworkwell.com. To access OHBS-CA's online Grievance Form, enter your access code to log in and click on "Grievance/Complaint Form" in the Quick Links section.

Please see page 2 for important information regarding member grievance rights.

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Expedited Appeal. An expedited appeal may be requested in those cases where care is in progress, and the case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. You or your provider should call OHBS-CA as soon as possible at 1-800-999-9585. Your appeal will be reviewed, a decision made, and you and your treating provider will be notified as soon as possible to accommodate your clinical condition, but not to exceed seventy-two (72) hours of OHBS-CA's receipt of the expedited appeal request. You will be notified in writing of OHBS-CA's determination. Additionally, OHBS-CA will provide the California Department of Managed Health Care ("Department") with a written statement on the disposition or pending status of the expedited appeal within three (3) days of receipt of the appeal request. If you are requesting an expedited appeal, you may also request that a separate expedited Independent Medical Review be conducted at the same time by the California Department of Managed Health Care.

California Department of Managed Health Care Notification Grievance Process and Independent Medical Review

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 **1-800-999-9585** or **711 for TTY (at operator request, say "1-800-985-2410")** 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 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-HMO-2219)** or **(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.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

English

IMPORTANT LANGUAGE INFORMATION:
You may be entitled to the rights and services below. These rights apply only under California law. However, these rights do not apply to all California residents. These rights do not apply to all languages.

You can get an interpreter to help you talk with your doctor or health plan. To get help in your language, please call your health plan at 1-800-999-9585 or call the number on your ID card.

Language services are at no cost to the enrollee. Written information may be available in some languages. If you need more help, call HMO Help Line at 1-888-466-2219.

Español

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA:
Usted puede tener derecho a los derechos y servicios que se indican a continuación. Estos derechos se aplican sólo bajo la ley de California. No obstante, estos derechos no se aplican a todos los residentes de California. Estos derechos no se aplican a todos los idiomas.

Puede obtener la ayuda de un intérprete para hablar con su médico o plan de salud. Para obtener ayuda en su idioma, llame a su plan de salud al 1-800-999-9585 o llame al número que se encuentra en su Tarjeta de Identificación (ID).

Los servicios en otros idiomas son gratuitos para el afiliado. Puede haber información escrita disponible en otros idiomas. Si necesita más ayuda, llame a la Línea de Ayuda de la HMO al 1-888-466-2219.
(Spanish)

中文

重要語言資訊：
您可能有權擁有下列權利並取得下列服務。這些權利僅按加州法律規定而適用。然而這些權利並不適用於所有加州居民。這些權利並不適用於所有語言。

您可以取得口譯員服務，協助您和醫師或健康計畫溝通。如需取得您的語言的協助，請撥打 1-800-999-9585 或會員卡背後的電話與您的健康計畫連絡。

計畫參加者不須支付語言服務費用。部分語言備有書面資訊。若您需要更多協助，請撥打 HMO 專線1-888-466-2219。
(Chinese)

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-999-9585.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-999-9585, 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang 1-800-999-9585.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Пожалуйста, позвоните 1-800-999-9585.

تنبيه: إذا كنت تتحدث **العربية)Arabic(**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال على 1-800-999-9585،

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけ ます。1-800-999-9585, にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره 1-800-999-9585، تماس بگیرید.

ध्यान दें: यदि आप **हि दी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शु कि उलप ध हैं। कृपया 1-800-999-9585, को कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-999-9585.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-999-9585, ។

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե **հայերեն (Armenian)** եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրում ենք զանգահարել 1-800-999-9585, համարով:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ **ਪੰ ਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। f ਕਰਪਾ ਕਰਕੇ 1-800-999-9585, 'ਤੇ ਕਾੱਲ ਕਰੋ।

โปรดทราบ: หากคุณพูด*ภาษาไทย* (Thai) มีบริการความช่วยเหลือด้ านภาษาให้ แก่คุณโดยที่ คุณไม่ต้ องเสียค่าใช้ จ่ายแต่อย่างใด โปรดโทรศัพท์ถึง 1-800-999-9585