

Member Grievance Form

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:

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

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 that involve 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 **(1-888-466-2219)** 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.