

GRIEVANCE COMPLAINT FORM

Dear Member:

The following is a Grievance Complaint Form that you may complete to file a complaint. If you believe that a member of the Plan's staff failed to provide trans-inclusive health care, you have the right to file a grievance using this form under the Plan's standard grievance procedures. If you need help with filling out this form or would like to submit your complaint by phone instead, please call us at **1-800-344-4222**. You can also submit a complaint on our website **concernhealth.com** through your employee portal (see the link to the grievance form at the bottom of the page).

You will receive an Acknowledgement of Receipt of Complaint letter within five (5) days of receipt of the complaint. The Acknowledgement of Receipt of Complaint letter lets you know that we received your complaint and are working to resolve it. Once we have finished our investigation, we will send you a Statement of Complaint Resolution within five (5) days of our decision (but in no case later than thirty (30) calendar days of us receiving your complaint).

You may receive our letters by mail or, if you have given us permission, by email. *Please be aware that email is not an entirely secure method of communication and involves the potential for messages to be sent to the wrong person or for Protected Health Information to be improperly accessed during storage or transit. By giving us permission to contact you by email, you are acknowledging and agreeing to those risks.*

By law, all complaints must be resolved within thirty (30) days of receipt. For situations involving an imminent and serious threat to the health of a Member, you may request expedited review and/or contact the Department of Managed Health Care for assistance.

Please note that we may contact you by phone to discuss your complaint and gather additional information we need to resolve the issue. Please be sure to provide a phone number that we can reach you at to discuss your complaint further if necessary.

Please mail your completed form to:

*Attn: Grievances and Appeals
Concern: EAP
2490 Hospital Dr, Suite #310
Mountain View, CA 94040*

If you have any questions regarding the grievance process or your specific grievance, please contact us at 1-800-344-4222. By law, all grievances must be resolved within thirty (30) days of receipt of the complaint.

CONCERN: Employee Assistance Program
2490 Hospital Drive, Suite 310
Mountain View, California 94040
1-800-344-4222



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Member Name: _____

Employer Name: _____

Member Address: _____

Do you consent to us contacting you by email? Yes No

Email: _____

Primary Phone #: _____ Cell Phone #: _____

Description of Complaint: (Attach additional sheets of paper if necessary)

Name of CONCERN Provider, Staff or Service (if known): _____

I hereby attest that the above information is true.

Signature: _____

Print Name: _____ Date: _____

ATTENTION CALIFORNIA RESIDENTS: IMPORTANT INFORMATION ON BACK

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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 **1-800-344-4222** 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 website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Can you read this letter?

Notice of Availability

You can request an interpreter at no cost to speak with CONCERN: EAP or a counselor. To request an interpreter or ask about written information in your language, first call CONCERN at 800-344-4222. Someone who speaks your language can help you. If you need more help, call the HMO Help Center at 888-466-2219

Aviso de Disponibilidad

Puede solicitar un intérprete sin cargo para hablar con CONCERN: EAP o un asesor. Para solicitar un intérprete o información escrita en su idioma, primero llame a CONCERN al 800-344-4222. Una persona que hable su idioma puede ayudarlo. Si necesita más ayuda, llame al Centro de Ayuda de HMO al 888-466-2219

通知：可提供的語言

在與 CONCERN (EAP 或者一位輔導員)

聯絡時，您可以請求免費提供口譯人員。如需請求提供口譯人員或以您的語言提供書面資料，請首先致電 CONCERN，電話號碼是 800-344-4222。將有一位會講您語言的工作人員幫助您。如果您需要更多幫助，請致電 HMO 協助服務中心，電話號碼是 888-466-2219。

Paunawa ng Kahandaan

Makaahiling kayo ng isang tagasalin ng wika upang makipag-usap sa CONCERN: EAP o isang tagapayo. Upang humiling ng isang tagasalin ng wika o magtanong tungkol sa nakasulat na impormasyon sa inyong wika, tumawag muna sa CONCERN sa 800-344-4222. Ang isang nagsasalita ng inyong wika ay makakatulong sa inyo. Kung kailangan ninyo ng karagdagang tulong, tawagan ang HMO Help Center sa 888-466-2219