IMPERIAL HEALTH PLAN
OF CALIFORNIA

IMPERIAL INSURANCE COMPANIES

Imperial Health Plan (HMO) (HMO SNP)/Imperial Insurance Companies (HMO) (HMO SNP)
Written Grievance Form (Part C & D)

This form is for use in filing a formal grievance (complaint) regarding any aspect of the care or service provided to you. Imperial Health Plan/Imperial Insurance Companies is required by law to respond to your grievances. A detailed procedure exists for resolving these situations.

Complete member information about the grievance below:

Last Name: Click or tap here to enter text. **First Name:** Click or tap here to enter text. **Middle Initial:** Click or tap here to enter text.

Address: Click or tap here to enter text. **City, State, Zip:** Click or tap here to enter text.

Home Phone Number: Click or tap here to enter text. **Alternate Phone Number:** Click or tap here to enter text.

Member ID: Click or tap here to enter text. **Date of Birth:** Click or tap here to enter text.

Write below what your grievance is about. Give date(s), time(s), person(s), place(s), service(s) etc. involved. Please attach copies of any additional information that may be helpful to your grievance. (i.e., notices received, medical records, billing statement, etc.) Use another sheet of paper if necessary.

Click or tap here to enter text.

Member Signature: Click or tap here to enter text. **Date:** Click or tap here to enter text.

If you are the member's representative and filing the grievance on the member's behalf, please sign below. You will also need complete the Appointment of Representative (AOR) Form on the Imperial Health Plan/Imperial Insurance Companies website www.imperialhealthplan.com and send this grievance with the AOR Form.

Signature of Representative: Click or tap here to enter text. **Date:** Click or tap here to enter text.

How to Send Your Grievance

- **Fax:** Submitting a written grievance or a completed Imperial Health Plan/Imperial Insurance Companies Grievance Request Form by fax to **1-626-380-9049.**
- **Email:** appealsgrievances@imperialhealthplan.com with a completed Imperial Heath Plan/Imperial Insurance Companies Grievance Request Form.
- **Send a letter to us**. **Mail your written request to:**

  Imperial Health Plan/Imperial Insurance Companies
  Attn.: Appeals & Grievances
  PO Box 60874
  Pasadena, CA 91116

- **Call Member Services**: at 1-800-838-8271 TTY: 711 Monday through Sunday, 8:00 am to 8:00 pm PST except holidays during October 1 through March 31 and Monday through Friday 8:00 am to 8:00 pm PST April 1 through September 30 except holidays and they will complete this form for you.

Imperial Health Plan/Imperial Insurance Companies must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 24 hours for an urgent grievance and 30 days for a standard grievance after receiving your grievance. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay. In certain circumstances you can file an expedited grievance.

Office Use Only:

Imperial Representative Name: Click or tap here to enter text. **Date:** Click or tap here to enter text.

AOR on File: ☐ **Yes** ☐ **No**

Materials Preference (from application) ☐ **Spanish** ☐ **Braille** ☐ **Large Print** ☐ **Audio CD**

☐ **Other: _____**

Imperial Health Plan. (HMO) (HMO SNP) /Imperial Insurance Companies (HMO) (HMO SNP) is dedicated to ensuring their members have a complete understanding of their Medicare rights, protections, and responsibilities as an Imperial Health Plan/Imperial Insurance Companies member. **Should you have additional questions, please call Imperial Health Plan Member Services at the telephone number listed above.**

Imperial Health Plan/Imperial Insurance Companies is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan/Imperial Insurance Companies depends on contract renewal.

Imperial Health Plan of California (HMO) (HMO SNP)/Imperial Insurance Companies (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-838-8271 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-838-8271 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-838-8271 *(TTY：711).*