

**Magellan Health Services\***  
**GRIEVANCE FORM**

<b>IMPORTANT:</b> Can you read this in English? If not, we can have someone help you read it. For free help, please call your program toll-free number.**	<b>IMPORTANTE:</b> ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame a su número gratuito.**
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We are very interested in hearing your concerns. Please complete this form and mail it to us, or if you prefer, contact us at your program toll-free number.\*\*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Health Plan or Sponsor (The organization through which you are receiving EAP or behavioral health services from Magellan): \_\_\_\_\_

May Magellan use your name in the investigation of this grievance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
May Magellan contact you by mail?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
May Magellan contact you by telephone?	<input type="checkbox"/> YES --Phone # _____	<input type="checkbox"/> NO
Would you like written notification acknowledging receipt of your grievance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like written notification of the outcome of your grievance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like verbal notification of the outcome of your grievance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Special instructions for contacting you (for example, time of day, person with whom it is okay to leave messages, etc.): \_\_\_\_\_

Name of Provider: \_\_\_\_\_ Approximate date this provider was last seen: \_\_\_\_\_

Complaint: (Attach additional pages if needed)

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 **1-800-424-1565\*\*** 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)** 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.

\_\_\_\_\_  
Signature Date

Please send completed form to:  
Comment Coordinator, Magellan Health Services  
300 Continental Boulevard, Suite 240, El Segundo, California 90245

\*Magellan subsidiaries in California are Human Affairs International of CA, and Magellan Health Services of California, Inc.-Employer Services.  
\*\*If you are speech or hearing impaired, call our toll free TTY number **1-800-456-4006** for assistance.