Alignment Health Plan®

PART C GRIEVANCE AND APPEALS/ PART D GRIEVANCES FORM

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. Your health plan is required by law to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call the Customer Services department of your provider group and/or your health plan's Customer Service department. Health plan customer service contact information is provided on the back of this sheet, and may also be found on your health care card.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION:			
Member Name (Last, first, middle initial):			Medicare Number:
Address:			Home Phone Number: ( ) –
City:	State:	Zip:	Work Phone Number: ( ) –
Name of Employer or Group:			Enrollment ID Number:
Birth Date: (MM/DD/YYYY) (/ /)	Gender: ☐ Male ☐ Female ☐ Non-binary ☐ I use a different term ☐ I choose not to answer		
Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:			
Name:			Telephone Number: ( ) –
Relationship to Member:	Address:		
City:		State:	Zip:
Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.			
Please sign and MAIL or FAX to your health plan (see page # 2 for health plan address)			
Signature of Representative:	**Signature Date:** / /		

SEND YOUR MEMBER APPEAL AND/OR GRIEVANCE LETTER TO YOUR HEALTH PLAN AT:

HEALTH PLANS: ALIGNMENT HEALTH PLAN	PHONE/FAX 1-866-634-2247 MEMBER SERVICES
Attn: Grievance & Appeals 1100 W. Town & Country Road #300 Orange, CA 92868	TTY: 711 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. Fax: 1-323-201-5690

INFORMATION FOR ALL ALIGNMENT HEALTH PLAN MEMBERS

YOU MAY HAVE THE RIGHT TO APPEAL.

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

WHO MAY FILE AN APPEAL?

You or someone you name to act for you (your authorized representative) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at: (866) 634-2247 to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY: 711

If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call your plan or see your Evidence of Coverage.

Alignment Health Plan is an HMO, HMO POS, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Nevada, North Carolina and Texas Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

THERE ARE TWO KINDS OF APPEALS YOU CAN FILE:

Standard (30 days) – You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour review) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30days.

WHAT DO I INCLUDE WITH MY APPEAL?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

HOW DO I FILE AN APPEAL?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to your health plan at the address indicated on the Alignment Health Plan Member Appeal & Grievance Form.

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax using the plan contact information indicated on the Alignment Health Plan Member Appeal & Grievance Form.

WHAT HAPPENS NEXT?

If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Alignment Health Plan If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

OTHER CONTACT INFORMATION:

If you need information or help, call us at: (866) 634-2247

OTHER RESOURCES TO HELP YOU:

Medicare Rights Center:
Toll Free: 1-888-HMO-9050
TTY/TTD:

ELDER CARE LOCATOR

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227) TTY/TTD: 1-877-486-2048

OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC (June 2001)