Scripps Health Plan

GRIEVANCE RESOLUTION PROGRAM

Scripps Health Plan staff will answer your questions and attempt to resolve any problem satisfactorily. We have a grievance program designed to resolve your concerns or complaints in a timely and effective manner.

If you have a question or concern, we encourage you to contact our Customer Service Department. We have trained staff available to assist you in filing your grievance and resolving your concern. The Scripps Health Plan Customer Service staff can be reached at the following number at **1-844-337-3700** or TTY at **1-888-515-4065** for the hearing and speech impaired.

If you wish to file a grievance in writing, please complete the attached form and mail or fax the details of your problem to:

Scripps Health Plan
Attention: **Appeals and Grievances**
Mail Drop: 4S-300
10790 Rancho Bernardo Rd
San Diego, CA 92127
Fax: **858-260-5879**

Upon receipt of your grievance, Scripps Health Plan will send you a written acknowledgement letter within five (5) calendar days with the name of the person handling your concern. We will make every effort to promptly resolve your concern and will provide you with a written response as soon as possible, typically within thirty (30) calendar days. Occasionally, issues requiring extensive review may take longer to resolve. In such cases, we will provide a written response or status within thirty (30) calendar days of receipt of your concern. You may request an expedited grievance if you feel that waiting thirty (30) calendar days could cause serious harm to your health or your ability to function for reasons including but not limited to severe pain, or potential loss of life, limb or major bodily function; we will provide you with a decision within three (3) calendar days.

Scripps Health Plan will assure that there is no discrimination against you solely on the grounds that you have filed a grievance or complaint. You, as the member, also have the right to request a conference as part of the grievance system. We would also like to inform you of the following information:

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* ***1-844-337-3700*** *or TTY at* ***1-888-515-4065*** *for the hearing and speech impaired 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.*

TODAY'S DATE:	**DATE OF SERVICE OR INCIDENT:**
NAME OF FACILITY, PROVIDER OR STAFF RELATED TO INCIDENT:	
MEMBER NAME:	**SCRIPPS HEALTH PLAN ID #:**
ADDRESS:	**HOME TELEPHONE:**
CITY, STATE, ZIP:	**WORK PHONE NUMBER:**
DATE OF BIRTH:	
If a grievance is being filed by anyone other than the Member, please provide the following information:	
NAME OF PERSON FILING:	**DAYTIME TELEPHONE:**
ADDRESS:	**RELATIONSHIP TO MEMBER:**
CITY, STATE, ZIP:	**DATE OF BIRTH:**
Do you have an incurable or irreversible condition that has a high probability of causing death within one year or less (terminally), and you would like to request a conference?	☐ **Yes** ☐ **No**
Is this related to a denial for treatment, services, or supplies deemed to be experimental or investigational?	☐ **Yes** ☐ **No**

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Is this an Expedited Grievance? Check "Yes" if you feel that waiting for 30 days could seriously harm your health or ability to function for reasons including but not limited to severe pain or potential loss of life, limb or major bodily function**.**	☐ **Yes** ☐ **No**
Please provide details related to the incident for which you are filing a Grievance including dates and times, names of individuals and locations. Please attach documentation if you need additional space.	

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SHPS USE ONLY	**DATE RECEIVED:**
EMPLOYEE (receiving grievance):	**PHONE**:
FOLLOW UP ACTION:	
RESULT/DECISION:	
DATE CLOSED:	**CSR TRACKING #**