Member Complaint Form

CIGNA Behavioral Health of California

CIGNA Behavioral Health of California
Customer Service
450 N. Brand Boulevard, Suite 500
Glendale, CA 91203
(800) 753-0540

There are two sides to this form. Please print clearly. Complete all sections of this form.

I am submitting a written expression of concern and/or dissatisfaction to CIGNA Behavioral Health of California.

☐ **Check this box if this case involves an imminent and serious threat to you or the health of the patient, including but not limited to severe pain, the potential loss of life, limb, or major bodily function. If it does, please phone CIGNA Behavioral Health of California Customer Service at (1-800-753-0540) immediately to let them know.**

Please read the enclosed brochure about your rights and the appeal procedure. To serve you quickly, it is important that you provide as much of the information as possible. If you have any questions about the meaning of anything on this form, please call Customer Service at (1-800-753-0540).

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 **1-800-753-0540** 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.

You also have the right to initiate an independent medical review (IMR) of your appeal from the Department of Managed Health Care. You may apply for an independent medical review for disputed health care services that have been denied, modified, or delayed by the Healthplan or one of its contracting providers, based on whole or in part on a decision that the health care service is not Medically Necessary. You should first attempt to resolve your appeal through the Healthplan s appeal process. For more information regarding the IMR process please call customer service 1-800-753-0540.

Member Information (Member complete this information)

Name (Last, First, Middle Initial) | Member Identification No.

Mailing Address (Street, City, State, Zip)

Telephone No. (Day) (Evening)

Name of person filing complaint (if other than member)

Patient Information (Complete only if Patient is other than member)

Name (Last, First, Middle Initial) | Relationship to Member | Social Security No.

Mailing Address (Street, City, State, Zip)

Telephone No. (Day) (Evening)

When completed, mail this form to:
CIGNA Behavioral Health of California
Customer Service
450 N. Brand Boulevard, Suite 500
Glendale, CA 91203
or, in an emergency, fax it to: (818) 551-2787

FOR INTERNAL USE ONLY

☐ Complaint ☐ Initial Determination
☐ Appeal

CONTINUED ON REVERSE

Member Complaint Information

What is the name, phone number and address of the physician or provider this complaint is about?

Name | Telephone No.

Address (Street, City, State, Zip)

Briefly outline the specific details of your complaint. Identify what the complaint is, and WHEN the events you describe took place. If helpful, please provide COPIES of all itemized bills, checks (both sides), and correspondence related to this complaint.

Attach additional pages to this form, if needed.

Have you sent any records, correspondence, or other complaints about this case to CIGNA Behavioral Health Customer Service or anyone else connected with CIGNA Behavioral Health? If so, when did you send it and to whom did you send it? Please include their phone or facsimile number if you know it.

CIGNA Behavioral Health Contact | Telephone / Facsimile No.

Date(s)

Certification I certify that this information is true and correct.

Member / Patient Signature | Date