Evernorth Behavioral Health of CA, Inc.

Customer GRIEVANCE FORM

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

Evernorth Behavioral Health of California
Central Appeals Unit
PO Box 188064
Chattanooga, TN 37422
1.800.753.0540

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

IN AN EMERGENCY, CALL 911 OR GO DIRECTLY TO THE NEAREST EMERGENCY ROOM.

☐ **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 Evernorth 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 **1-800-244-6224**, (Dial **711** (TTY) 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.

CUSTOMER INFORMATION (Customer to 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 the customer)

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:
Evernorth Behavioral Health of California
Central Appeals Unit
PO Box 188064
Chattanooga, TN 37422
Fax: 1.877.815.4827

FOR INTERNAL USE ONLY
☐ Complaint ☐ Initial Determination
☐ Appeal

continued on next page

Member Complaint Information

What is the name, phone number and address of the provider or facility 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 Evernorth Behavioral Health customer service or anyone else connected with Evernorth Behavioral Health? If so, when did you send it and to whom did you send it? Please include their phone or fax number if you know it.

Evernorth Behavioral Health Contact	Telephone No.	Fax No.

Date(s)

Certification I certify that this information is true and correct.

Member/Patient Signature	Date

