



The Carousel Network

**Chronic Neuroimmune Disease
Information and Support for Sonoma County**
122 Calistoga Road, #216
Santa Rosa, CA 95409
www.cndsinfo.net

Health Care Grievance Form

This is a health care grievance form and filing instructions from the California Department of Corporations on how to file a complaint about a health plan.

The Carousel Network (TCN) offers information on the various diseases and disorders associated with chronic neuroimmune diseases, such as chronic fatigue syndrome, fibromyalgia, multiple chemical sensitivity, autoimmune thyroid disease, etc. The information is intended to help patients and caregivers make informed decisions about the patient's health, diagnostic testing, and treatment in conjunction with their health care practitioners. TCN does not diagnose patients nor recommend specific medical or palliative treatments.

***The Carousel Network is a 501(c)3 nonprofit supported by memberships and donations.
Membership is \$20/year; make checks payable to The Carousel Network, POB 366, Fulton CA 95439-0366.***

K-2 / Rev. 09/04

California Department of Corporations Health Care Grievance Form

REQUEST FOR ASSISTANCE FORM INSTRUCTIONS

I. Please Read and Follow These Important Instructions

Please review these instructions prior to completing the attached Request for Assistance form. We hope these instructions will help you to better understand the role of the Health Plan Division of the Department of Corporations ("Department") in its review of complaints against health care service plans ("health plans").

II. Health Plan Grievance Procedure

The Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") requires health plans to establish a grievance system for resolution of enrollee complaints. The Knox-Keene Act requires enrollees to file a complaint with their health plan before requesting assistance from the Department's Health Plan Division. If the health plan does not resolve your complaint within 60 days, you may wish to file a Request for Assistance with the Department's Health Plan Division. However, if your complaint involves an imminent and serious threat to the health of the patient, you should immediately contact the Health Plan Division's Consumer Services Unit at (800) 400-0815.

III. What the Health Plan Division of the Department of Corporations *Can Do*

The Department's Health Plan Division regulates health plans in the State of California. The Health Plan Division is responsible for ensuring that health plans comply with the Knox-Keene Act (Health and Safety Code Section 1340, et seq.) and the Commissioner of Corporations' regulations (California Code of Regulations, Title 10, Section 1300.40, et seq.). Health and Safety Code Section 1368 requires the Department's Health Plan Division to review complaints. This review is comprised of an examination of all written information provided by the complainant and the health plan, including relevant medical records if necessary. Interviews of the complainant or other witnesses are not part of the Health Plan Division's request for assistance process. Accordingly, please make certain that you provide the Health Plan Division with copies of all information that you want considered.

IV. What the Health Plan Division of the Department of Corporations *Cannot Do*

The Department's Health Plan Division is not a court of law. The Health Plan Division cannot give legal advice or act as your attorney. The Health Plan Division's request for assistance process should not be considered a way to gather facts (also known as "discovery") in preparation for any potential legal action. An individual need not wait for the completion of the Health Plan Division's review process before pursuing any other legal remedy. A Request for Assistance form may be filed with the Health Plan Division even if an individual has retained legal counsel and is pursuing arbitration or a lawsuit.

V. How You Can Help Us Assist You

Please complete all sections of the Request for Assistance form. Your responses should be typed or printed in ink.

Supporting documents are important. Please attach a photocopy of all documents, including letters, contracts, records (bills, checks [both sides]), and other papers relating to your request for assistance. Please **DO NOT** send originals; they cannot be returned.

As you respond to Item 16 of the Request for Assistance form (summary of complaint), please include clear, brief answers to the questions of, "who, what, where, when, and how." Should you have any questions concerning the Request for Assistance form, please contact the Health Plan Division's Consumer Services Unit at the toll-free number listed above.

HPD 500.507A (Info) (9/97)

NOTICE REQUIRED BY THE INFORMATION PRACTICES ACT OF 1977
(California Civil Code Section 1798.17)

(a) The Health Plan Division of the Department of Corporations of the State of California, requests the information solicited by the forms attached to this Notice.

(b) The Chief Administrative Officer, 980 Ninth Street, Sacramento, CA 95814, telephone number (916) 445-5541, is responsible for the system of records and shall, upon request, inform individuals regarding the location of the Department of Corporations' records and the categories of persons who use the information in the Department of Corporations' records.

(c) The Department of Corporations' records are maintained pursuant to one or more of the following statutes: Health and Safety Code Sections 1344, 1351, 1351.1, 1352, 1353, 1368(b) 1368.02 and 1384.

(d) The submission of all items of information is voluntary.

(e) Failure to provide all or any part of the information requested by the attached form may preclude the Health Plan Division of the Department of Corporations from reviewing your complaint.

(f) The principal purposes within the Department of Corporations for which the information is to be used is as part of the process to determine: (1) whether a license, qualification, registration or other authority should be granted, denied, revoked or limited in any way; (2) whether business entities or individuals licensed or regulated by the Department of Corporations are conducting themselves in accordance with the applicable laws; and/or (3) whether laws administered by the Department of Corporations are being or have been violated and whether administrative action, civil action, or referral to appropriate federal, state or local law enforcement or regulatory agencies is appropriate.

(g) Any known or foreseeable disclosures of the information pursuant to subdivision (e) or (f) of Civil Code Section 1798.24 may include transfers to other federal, state, or local law enforcement or regulatory agencies.

(h) Subject to certain exceptions or exemptions, the Information Practices Act grants an individual a right of access to personal information concerning the requesting individual which is maintained by the Department of Corporations. However, Government Code Section 6254 provides that records of complaints to or investigations conducted by the Department of Corporations are exempt from disclosure except as required by law. Additionally, Evidence Code Section 1040 provides a privilege against disclosure of official information where a court determines that the necessity for confidentiality outweighs the public interest in disclosure.

HPD IPA Notice: 5/97

REQUEST FOR ASSISTANCE FORM

PLEASE READ THE INSTRUCTION SHEET PRIOR TO COMPLETING THIS FORM. PLEASE TYPE OR PRINT CLEARLY AND COMPLETE ALL ITEMS ON THIS FORM.

Call Identification Number: _____

1. Complainant's Full Name:

2. Complainant's Address:

City: _____ State: _____ Zip: _____

3. Telephone: Home () _____ Work () _____

4. Subscriber's Name and Address, if different from Complainant:

5. Subscriber's Identification Number: _____

6. Name of Group Coverage, if Applicable: _____

7. Are You a Medi-Cal Beneficiary? Yes ____ No ____

Are You a Medicare Beneficiary? Yes ____ No ____

8. Complete Name of Health Plan: _____

9. Health Plan's Address: _____

City: _____ State: _____ Zip: _____

10. Have you previously written to the Health Plan Division of the Department of Corporations about this specific matter? Yes ____ No ____ If yes, please furnish:

File number: _____ Date Written: _____

11. Do you know whether the health plan has a grievance system? Yes ____ No ____

If yes, have you used it? Yes ____ No ____

12. Have you contacted the health plan complained about? Yes ____ No ____

If yes, state the date(s) and person(s) contacted: _____

13. Have you reported this to any other governmental agency(ies)? Yes ____ No ____

If yes, please state name(s) of agency(ies) and the file number(s):

14. Is there a civil action (lawsuit) pending? Yes____ No____

If yes, please attach a photocopy of the court documents and state the name of the county, case number, date filed:

15. Do you have an attorney representing you? Yes ____ No ____

Note: A Request for Assistance form may be filed with the Health Plan Division even if you have retained legal counsel and are pursuing arbitration or a lawsuit.

16. State, as briefly as possible, the essential facts of this complaint (include "who, what, where, when and how"). Attach additional paper, if needed.

The information provided is furnished voluntarily. I understand it is not mandatory that I furnish the requested information, but failure to do so may delay or even preclude further consideration of my request for assistance.

I understand that a copy of this Request for Assistance form may be sent to the health plan.

Date: _____ Signed: _____

Please complete and sign the form, attach photocopies of all of the documents and records, and mail them to:

Department of Corporations
Health Plan Division
Consumer Services Unit
320 West 4th Street, Suite 750
Los Angeles, California 90013-1105
1-(800)-400-0815

If you have any questions regarding this form, please call our toll free telephone number.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: PLEASE FILL IN YOUR NAME AND THE NAME OF THE HEALTH PLAN IN THE SPACES BELOW, SIGN AND DATE THIS AUTHORIZATION, AND RETURN IT TO THE LOS ANGELES OFFICE OF THE HEALTH PLAN DIVISION OF THE DEPARTMENT OF CORPORATIONS, ATTN: CONSUMER SERVICES UNIT.

IN THE EVENT THE ENROLLEE CANNOT SIGN THIS AUTHORIZATION ON HIS/HER OWN BEHALF (FOR EXAMPLE, IF ENROLLEE IS A MINOR), A PARENT OR GUARDIAN SHOULD COMPLETE FORM FOR ENROLLEE. PLEASE CALL THE HEALTH PLAN DIVISION'S CONSUMER SERVICES UNIT AT (800) 400-0815 IF YOU HAVE ANY QUESTIONS.

_____ (person authorizing release) on
behalf of _____ (enrollee's name)

hereby authorizes _____ ("Health Plan") to release to the Department of Corporations ("Department") his/her medical record(s) in the custody and/or control of the Health Plan including but not limited to all medical records in the possession of health care providers and any other information in the custody and/or control of the Health Plan concerning care provided to him/her relating to the Request for Assistance form filed with the Department.

This authorization for release of information may be revoked or withdrawn at any time and a revocation or withdrawal will apply to all information not previously released pursuant to this authorization.

This authorization for release of information will expire one year following the date indicated below and the expiration will apply to all information not previously released pursuant to this authorization.

YOUR MEDICAL RECORDS WILL ONLY BE OBTAINED IF IT IS DETERMINED TO BE NECESSARY IN ORDER TO COMPLETE A REVIEW OF YOUR REQUEST FOR ASSISTANCE. THE MEDICAL RECORDS REQUESTED SHALL INCLUDE ONLY THOSE MEDICAL RECORDS RELEVANT TO A REVIEW OF YOUR MATTER. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

THIS MEDICAL AUTHORIZATION FORM IS NOT MANDATORY. HOWEVER, FAILURE TO PROVIDE THIS FORM MAY PRECLUDE FURTHER CONSIDERATION OF YOUR REQUEST FOR ASSISTANCE.

Signed _____ Date _____

HPD500.531(5/97)