

# Member Grievance & Appeal Form



Date Filed: \_\_\_\_\_

**Step 1:** Complete the form below with your Alliance information.

Last Name:	First Name:
Alliance ID #:	Cell Phone #:
Date of Birth:	Other Phone #:
Address:	
City, State and Zip Code:	
I have Alliance coverage through:	
<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Alliance Care IHSS	
<input type="checkbox"/> I request an expedited review because this issue involves a serious threat to my health.	
<input type="checkbox"/> I have a terminal illness and have been denied treatment. I request a conference with Alliance medical staff.	
<input type="checkbox"/> I asked the following person or provider to help me with my grievance or appeal:	
Name of person:	Relationship:
If a provider, Provider Phone #:	Provider Fax #:

**Step 2:** Describe what happened or what action you are appealing.

For appeals, what is the modified or denied authorization #:	
For a grievance, who is your grievance against? Provider Name:	
When did this happen?	Date:
Describe what happened:	

**Step 3:** Sign and date this form.

I certify that the statements made above are true and correct to the best of my belief:

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Step 4:** Return this form via email, fax or regular mail:

**Regular mail:** Alliance Grievance Department, 530 West 16<sup>th</sup> St., Ste. B, Merced, CA 95340

**Email:** [grievancecoordinator@ccah-alliance.org](mailto:grievancecoordinator@ccah-alliance.org)

**Fax:** 831-430-5579

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[www.thealliance.health](http://www.thealliance.health)

10-2023

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**For IHSS members, please read the California Department of Managed Health Care statement below.**

## **California Department of Managed Health Care Statement**

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 **(800-700-3874)** or **TTY (800-735-2929)** 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](http://www.dmhc.ca.gov)** has complaint forms, IMR application forms, and instructions online.