AltaMed Health Network

**APPEALS & GRIEVANCES**

All AltaMed Health Network members have the right to file a grievance or appeal on any decision. By definition, a grievance is a written or verbal expression of a member's dissatisfaction with the care or services provided, and may be used to request a review of a complaint or inquiry that has not been resolved to the member's satisfaction. A complaint (or inquiry) is a member's written or verbal request for information or assistance, or an expression of concern about an issue. A complaint can become a grievance. Complaints and/or grievances should be submitted to the member's assigned health plan (create hyperlink listing AHN full Service Contracted Health Plans), either by phone or in writing. Should the grievance be received or sent directly to AHN, it will be forwarded by the Medical Services Department to the member's health plan within 24 hours.

An appeal is a written or verbal request to reconsider the initial determination of a denied healthcare service or claim. Appeals can be requested by submitting a written or verbal notification to your health plan representative to appeal any decision that the member believes is unfair or unjust.

Members have the right to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex electronically through the Office for Civil Rights Complaint Portal or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. Complaint forms are available at the U.S. Department of Health and Human Services website. Complaints filed with the U.S. Department of Health and Human Services, Office for Civil Rights must be filed within 180 days of the date of the alleged discrimination.

**AFFIRMATION STATEMENT**

AltaMed Health Network (AHN) Utilization Management (UM) Department and UM Committee involved in the evaluation and improvement of quality care and services, agree to appropriately approve and deny services and discourage under-utilization.

AHN affirms that:

- UM decision making is based only on appropriateness of care and service and the existence of coverage.
- AHN or its contracted entities, do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.
- AHN or its contracted entities do not offer financial incentives to UM decision makers that encourage decisions that result in denials of care or under-utilization.
- Member healthcare is not compromised.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence:
    - Hiring
    - Compensation
    - Termination
    - Promotion
    - Any other similar matter

**DECISION MAKING GUIDELINES FOR TREATMENT REQUESTS & REFERRALS**

AltaMed Health network utilizes evidence-based guidelines when making decisions regarding referral requests for services. As a member, you may ask for free copies of all information used to make a decision regarding your requested service. If you would like a copy of the actual benefit provision, guidelines protocol, or criteria that we based our decision on, you may call: 855-848-5252

**INTERPRETATION & TRANSLATION**

Limited English Proficient or **LEP** Enrollee: a person who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

You have the right to no-cost interpreting services, as well as American Sign Language. You can get these services 24 hours a day, seven days a week. You can request interpreting or translation services, information in your language or another format such as large print or audio, or auxiliary aids and services by calling the Member Services phone number at the Health Plan listed on the back of your health insurance plan ID card. You can also ask your AHN provider's office for assistance in doing this. Members who are deaf or hard of hearing can access **TDD/TYY** Services directly by calling California Relay Service (CRS) by dialing **711** 24 hours a day, 7 days a week, including holidays.

**Complaints Related to Language Assistance Services**
You can file a complaint at any time with your Health Plan if:

- You feel that you were denied services because you do not speak English
- You cannot get an interpreter
- You have a complaint about the interpreter
- You cannot get information in your language or format
- Your cultural needs are not met