

Member Grievance Form

At Alameda Alliance for Health (Alliance) your satisfaction is important to us. If you have a problem with the Alliance, you have the right to make a complaint. This is also called filing a grievance.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below. You can attach extra pages if needed.
2. Please submit the completed form by mail or in person:
 - **Mail:** Alameda Alliance For Health, Attn: Member Services, PO Box 2818, Alameda, CA 94501-0818
 - **In person:** 1240 South Loop Road, Alameda, CA 94502
(Lobby Hours: Tuesday, Wednesday, and Thursday, 9 am – 11 am and 2 pm – 4 pm)

If you have questions, or if you need help with this form, please contact:

Alliance Member Services Department, Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567** • Toll-Free: **1.877.932.2738**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

www.alamedaalliance.org

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____
 Date of Birth: _____ Alliance Member ID #: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ ☐ Home ☐ Cell

If another person is filling out this form:

Name of Person Filing Grievance: _____ Phone Number: _____
 Where Incident Occurred: _____ Date Incident Occurred: _____
 Please describe the problem you had: _____
 How have you tried to resolve this problem? _____
 What do you think is a good solution to your problem? _____

SECTION 2: SIGNATURE

Full Name (Print): _____
 Signature: _____ Date: _____

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 **1-510-747-4567** 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 an 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.dmhca.gov** has complaint forms, IMR application forms, and instructions online.

You also have the right to file a grievance if you believe that the Alliance failed to provide trans-inclusive health care. "Trans-inclusive health care" means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse or intersex (TGI), honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.