Bright HealthCare
PO Box 1519
Portland, ME 04104

«Date»

«Addressee_First_Name» «Addressee_Last_Name»
«Address_Line_1»
«Address_Line_2»
«City», «State» «Zip»

Member Appeal, Complaint, or Grievance Form

To file a member appeal, complaint, or grievance you may submit online at https://brighthealthcare.com/individual-and-family/resource/member-hub, complete the form and click "Submit". You may also upload additional documentation.

Print and mail this completed form with any attachments to:

Bright HealthCare
PO Box 1519
Portland, ME 04104

You can also send this completed form with any attachments via fax:

Fax: <fax>

Reminder: Keep a copy of this form and all documents/correspondence related to this issue.

Tell us about you:

Date: _____

Member Name: _____ Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Tell us about your issue:

What is this issue about:

☐ A medication
☐ A medical service (or medical equipment)
☐ An issue not related to a medication or medical service
☐ Claims and Authorization of Services

Date of Incident: _____

Describe What Happened (Attach additional pages, if necessary):

_____

_____

_____

_____

_____

_____

What documents are you including:

☐ Receipt
☐ Medical Bill(s)
☐ Medical Record(s)
☐ Letter from your provider
☐ None
☐ Other_____

Urgent appeals are available <u>only</u> for services that have not been provided.

Are you requesting an urgent appeal? ☐ Yes ☐ No *Standard decisions are made within 30 calendar days.*
If yes, you must have your <u>treating physician</u> check the appropriate box(es) below and sign the certification.

☐ My patient's health would be in serious jeopardy if required to wait for a standard appeal decision.
☐ My patient would experience pain that cannot be adequately controlled if required to wait for a standard appeal.

Physician Certification:

I hereby certify that the above, in my professional opinion, presents an urgent situation requiring that this member's (my patient) appeal be expedited.

_____

Treating Physician Signature Date Phone

Print Name: _____

Do you need to appoint a representative?

For "Authorized Representative", the Member must sign here and comply with the note below in order to authorize the representative to act on their behalf: _____

<u>Note</u>: Signing above does not automatically authorize the representative to proceed on your behalf. A proper HIPAA authorization is required in order for your protected health information to be shared with your representative. If there is no HIPAA authorization on file for this representative, an authorization will be sent to you to execute and return. Your appeal cannot be processed without all properly completed authorizations. Please note that a special authorization may also be required for behavioral health and family planning matters involving a member over the age of 13.

CONTACT INFORMATION OF PERSON FILING FORM

Address: _____ Daytime/cell phone: _____

Email: _____

I acknowledge that Bright HealthCare employees who need to know information pertaining to the services in question in order to process this form will also have access to and may review such information.

Information provided and included with this form becomes part of the permanent record. You will be sent an acknowledgment within 5 calendar days and a response within 30 calendar days (72 hours for urgent appeals) of Bright HealthCare's receipt of this form or your call.

_____ _____

Member Signature Date

HOW TO FILE A GRIEVANCE

Bright HealthCare has a formal process for reviewing member grievances. This process provides a uniform and equitable treatment of your grievance and a prompt response.

Bright HealthCare ensures that all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with visual or other communicative impairments. Such assistance shall include, but not be limited to, translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems, and other devices that aid disabled individuals to communicate.

Definition of a Grievance

A grievance is a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including quality of care concerns. A grievance includes a written or oral expression of dissatisfaction by an enrollee, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed. For grievances involving an imminent and serious threat to health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, Bright HealthCare will provide an expedited reconsideration of any decision to deny or modify a requested service.

Members have up to 180 calendar days from the date of an incident or dispute, or from the date the member receives a denial letter, to submit a grievance to Bright HealthCare.

Standard Grievance Review

Steps in the process

1. File your grievance with Bright HealthCare. You may also authorize someone to represent you. Authorization must be in writing. You may find a copy of the authorization form on the Bright HealthCare website at www.BrightHealthCare.com. Call Member Services for the authorization form at (844) 926- 4524. Your Member Services number is also on the back of your membership card.

   You can file your grievance by:

   a. Calling Member Services at (844) 926-4524;

   b. Mailing a letter or a completed grievance form which you can get on the website or by calling Member Services at (844) 926-4524; or

   c. Submitting a grievance form online via the Bright HealthCare Member Hub at https://brighthealthcare.com/individual-and-family/resource/member-hub.

2. Bright HealthCare will send you an acknowledgment letter within five (5) calendar days of receipt of your request.

3. Bright HealthCare will fully investigate your grievance, including all aspects of medical care involved. All medical records and/or responses that will assist with the review of your case are requested and reviewed by

Bright HealthCare. Clinical grievances are reviewed by staff medical personnel and physician specialists. Non-medical grievances are reviewed by grievance specialists. Bright HealthCare will provide a written response to you within 30 calendar days after Bright HealthCare receives your grievance.

Expedited Review

The grievance system includes an expedited review process for urgent grievances. A grievance is expedited when a delay in decision-making may seriously jeopardize the life or health of a member or the member's ability to regain maximum function, including, but not limited to, severe pain, potential loss of life, limb, or when a member, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly canceled, rescinded or not renewed.

Steps in the process

1. File your request for an **Expedited Grievance** with Bright HealthCare using one of the methods listed in the standard grievance process. You may also authorize someone to represent you. Authorization must be in writing. Contact Member Services for the authorization form or find the authorization form online at https://brighthealthcare.com/individual-and-family/resource/member-hub. Your Member Services number is on the back of your membership card. Calling Member Services is the recommended method for requesting an expedited review.

2. A physician will review your Expedited Grievance request and make a determination within 72 hours. If your request does not qualify for an expedited review, your grievance will be reviewed in the standard 30-day grievance process. You will be notified by mail if you do not qualify for expedited review.

3. If you believe your issue is urgent, may seriously jeopardize your life or health or your ability to regain maximum function, including but not limited to, severe pain, potential loss of life or limb, you believe your plan contract, enrollment, or subscription has been or will be improperly canceled, rescinded or not renewed, you may appeal directly to the Department of Managed Health Care without first participating in our grievance process.

Further Grievance Rights

If you are dissatisfied with our answer, you may be able to pursue one or more of the following grievance processes, depending on your situation and the grievance information contained in your Evidence of Coverage. If you need assistance, please contact Member Services at the number on the back of your membership card (1-844-926-4524). If your issue has not been resolved within 30 days or you are not satisfied with the outcome of our grievance process, you may be able to:

1. File a complaint with the Department of Managed Health Care (DMHC) provided that your Bright HealthCare health coverage is governed by them. Click on the following link to be directed to the DMHC website. http://www.dmhc.ca.gov/. You can file online at the DMHC website: http://www.dmhc.ca.gov/. Your grievance acknowledgment letter and response letter from Bright HealthCare will include information on how to contact the Department of Managed Health Care.

2. If your health coverage is not governed by the DMHC, it may be governed by the Department of Insurance. Please contact Member Services at 1-844-926-4524 if you are not sure which entity governs your health coverage. Your Member Services number is also on the back of your membership card.

3. Request Independent Medical Review: Independent Medical Review is available for decisions to deny payment on the basis that the services are not medically necessary, or that they are considered investigational or experimental, or for pre-service denials, modifications, or delays of authorization for a service as not medically necessary.

4. If your grievance involves a denial of health care service, information on the independent medical review process will be provided in our letters to you.

5. Have your case reviewed in an administrative hearing if you are a Medicare beneficiary or a Medi-Cal enrollee. Those rights are identified in your Evidence of Coverage.

6. Seek legal remedies in a court of law.

All Bright HealthCare Members

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 1-844-926-4524 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.