



Inter Valley Health Plan

For health. Not for profit.

300 S. Park Avenue
Pomona, CA 91769
(800)523-3142; TTY (800)505-7150

Member Appeal & Grievance Form

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. Inter Valley Health Plan **is required by law** to respond to your complaints or appeals, and we have a detailed procedure for resolving these situations. If you have any questions, please feel free to call us at: **Member Services 1-(800) 251-8191**. If you have a hearing or speech impairment, please call us at **TTY/TDD: 1-(800)-505-7150**.

Please print or type the following information:

Member Name (Last, first, middle initial) _____ Member ID Number _____

Home Address _____ Phone number _____

City, State, Zip _____ Date of Birth _____

Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:

Name: _____ Telephone # _____

Relationship to Member: _____

Address: _____

City: _____ State: _____ Zip: _____

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal. _____

Date _____ **Signature** _____

Date _____ **Signature of Representative** _____

You or your representative should email, mail, or deliver your signed written complaint or appeal request to the address below:

Inter Valley Health Plan
Attn: Grievance & Appeals Dept.
300 S. Park Avenue, P.O. Box 6002
Pomona, CA 91769

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at: (800) -251-8191 to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/ TDD (800) -505-7150. If you want someone to act for you, you and your authorized representative should sign, date, and send us page 1 of this form, which will serve as a statement naming that person to act for you.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage

There Are Two Kinds of Appeals You Can File:

Standard (30 days) - You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.
- If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to the address below:

**Inter Valley Health Plan
Attn: Grievance & Appeals Dept.
300 S. Park Avenue, P.O. Box 6002
Pomona, CA 91769**

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax at the numbers below:

**Phone: (800) 251-8191
TTY/TDD: (800)-505-7150.
Fax: (909) 620-6413**

What Happens Next? If you appeal, your plan will review our decision. After your plan review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare Advantage Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Other Contact Information:

If you need information or help, call us at:

**Toll Free: 1-(800) 523-3142
TTY/TDD: 1- (800) 505-7150**

Other Resources To Help You:

Medicare Rights Center:
Toll Free: 1-888-HMO-9050
TTY/TTD:

Elder Care Locator

Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY/TTD: 1-877-486-2048