

Grievance and Appeal Section

Grievance Process

You can file a grievance with Molina Healthcare. If you are not happy with the health plan, this is called a grievance. You can also file a grievance if you are not happy with one of our providers. The grievance process is available for members who have a complaint that cannot be resolved during the initial contact with the Plan and is not a matter subject to an appeal. You have 90 days from the event to file a grievance with the plan.

You can submit a grievance in person, in writing or by telephone. Molina Healthcare's Appeal and Grievance Coordinator can help you write your grievance. We will make a decision regarding your grievance within 30 days of receipt.

The Coordinator will look into your grievance. The Coordinator will ask other staff who know about your issue. This may be a nurse or a doctor who knows about the problem (if it is medical). Molina Healthcare will keep a written account of your grievance. It will be confidential (private). Grievances about the care you receive are sent to the Quality Improvement Department. The Department will investigate the complaint further.

If you would like to make a grievance, please call our Member Services Department at 1-888-898-7969.

Appeal Process:

You can file an appeal if Molina Healthcare denied, suspended, terminated, or reduced a requested service. This is called an adverse determination.

- You have 90 calendar days from receiving the denial to file an appeal.
- You have the right to appeal in person, in writing, or by telephone to the Appeals Review Committee of Molina Healthcare. Molina Healthcare's Appeal and Grievance Coordinator can help you write your appeal.
- You have the right to include an authorized representative throughout the appeals process and to attend the Appeals Review Committee meeting. You must inform us of your authorized representative in writing.
- You can bring any information that you feel will help the Committee make a better decision.
- The Coordinator will tell you the time and place the appeal will be heard.
- Molina Healthcare will use reviewers who were not involved in the initial decision to review.
- A decision will be mailed to you in 30 days from the date that Molina Healthcare received your appeal.
- Benefits may continue pending resolution of the Appeal. You may be required to pay the cost of the services if the denial is upheld.
- You have a right to ask for the benefit guidelines used to make this

decision.

- An additional 10 calendar days are allowed to obtain medical records or other pertinent medical information if Molina Healthcare can demonstrate that the delay is in the member's interest.

Expedited Appeal (Urgent Cases)

If you or your doctor believes that the usual 30 days timeframe for appeals will cause harm to your health, or affect your normal body functions, your appeal may be expedited (urgent). Expedited appeals are decided in 72 hours. You may file an expedited appeal with the Office of Financial and Insurance Regulation (OFIR) at the same time. You may request an expedited appeal with OFIR immediately after you have filed an expedited appeal with Molina Healthcare. If Molina Healthcare denies your request for an expedited appeal, you may request an expedited external review with OFIR within 10 days of the denial.

External Review by the Office of Financial and Insurance Regulation

You can ask for an external review if you do not get an answer within 30 calendar days from Molina Healthcare or if you are not happy with the result of your appeal. You may appeal in writing to OFIR for an external review. The appeal request should be sent to:

**Office of Financial and Insurance Regulation (OFIR)
Health Plans Division**

P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442
Fax Number: 1-517-241-4168

You must appeal in writing to OFIR within 60 calendar days after you receive the final answer from Molina Healthcare. Molina Healthcare can explain the external review process to you. We can also mail the external review forms to you. OFIR will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal.

You, your authorized representative or your doctor can also request an expedited appeal decision from OFIR at the same address above within 10 days after receiving an adverse determination. OFIR will send your appeal to an IRO for review. You will have a decision about your care within 72 hours.