

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.

You can make a grievance in person, in writing or by telephone. Molina Healthcare's Appeal and Grievance Coordinator can help you write your grievance.

The Coordinator will look into your grievance. The Coordinator will ask other staff who know about your problem. 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. We will respond to your grievance within 30 calendar days of receipt.

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 covered service.

- 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 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.
- A decision will be mailed to you in 30 calendar days from the day that Molina Healthcare received your appeal.
- 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 the member

requests the extension, or if Molina Healthcare can demonstrate that the delay is in the member's interest.

Expedited Appeal (Urgent Cases)

If a doctor believes that the 30 calendar day decision timeframe will cause harm to your health, or affect your normal body functions, Molina Healthcare will handle your appeal as expedited (urgent). Expedited appeals are handled in 72 hours. You may file an expedited appeal with the Office of Financial and Insurance Regulation (OFIR) at the same time.

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 the OFIR for an external review. The appeal request should be sent to:

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

P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442

You must appeal in writing to the 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. The OFIR will send your appeal to an Independent Review Organization (IRO) for consideration. A decision will be mailed to you in 14 calendar days of accepting your appeal.

If you are not happy with Molina Healthcare's final decision and you want your appeal request to be expedited, you have 10 calendar days to file an appeal to the OFIR.