



# Medi-Cal Grievance (Complaint) Form

## Section A: Member Information

Last Name		First Name		Initial
Date of Birth (MM/DD/YY)		Date of Incident		
Mailing Address		City	State	Zip
Evening Phone Number	Daytime Phone Number		Contact Hours (Please specify when you prefer to be called)	
Member Number				

## Section B: Please give a detailed reason for your grievance (complaint):

## Section C: Signature

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If the complaint is filed by a personal representative on behalf of the individual, complete the following and check the appropriate box.  
Print Name of Personal Representative:

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

Parent of Minor Child     Legal Guardian     Power of Attorney     Executor/Conservator

Other \_\_\_\_\_

Please return this form to:

Molina Healthcare of California  
Attn: Member Appeals and Grievance  
200 Oceangate, Suite 100  
Long Beach, CA 90802 or  
Fax (562) 499-0757

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 **1-888-665-4621**, **TTY users dial 711** 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](http://www.dmhc.ca.gov)** has complaint forms, IMR application forms and instructions online.