1333 Bush Street
San Francisco, CA 94109
415/292-8888
(TTY) 415/292-8898

Appeal for Reconsideration of Denial

Instructions: Please complete this form to request an appeal of our decision to deny, defer, or modify a service or payment of a service that you or your representative requested. Send the completed form to the address below. The Health Plan Associate will forward this form to the Chief Medical Officer or Director of Health Plan Services. The appropriate officer will ensure this form is forwarded to an impartial third party for review.

Date: _______________

To: Health Plan Associate
On Lok Lifeways
1333 Bush Street
San Francisco, CA 94109

From: ____
Name of Participant / Participant's Representative / Provider

____
Address and telephone number of the person identified above

_____________ ___________________
On Lok # Center

I, _____________________________________, participant / representative / provider (circle one),
Name

hereby appeal the denial, deferral, or modification of the following service(s) or payment for service:

____

____

for: ____
Name of person receiving service(s)

for the reason(s) below:

____

____

Please review my request and notify me of your decision as soon as possible.

______________________ _______________
Signature Date

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 **415-292-8895** or **1-888-996-6565** 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

For On Lok Lifeways Staff Use Only:

- ☐ On Lok Lifeways staff member who received the appeal:
  ____ Health Plan Associate
  ____ Social Worker
  ____ Other, specify: ________________________________
- ☐ Request received by the On Lok Lifeways staff member identified above: Date ________ Time ________
- ☐ Health Plan Associate notified of the appeal by telephone or e-mail: Date ________ Time ________
- ☐ Health Plan Associate sent a written acknowledgment to the participant: Date ________
- ☐ Health Plan Associate telephoned acknowledgement of receipt to the participant: Date ________ Time ________
- ☐ Health Plan Associate sent a written notification of the decision to the participant: Date ________ Time ________
- ☐ Health Plan Associate telephoned notification of the decision to the participant: Date ________ Time ________