EYEMAX VISION PLAN

Grievance Form

IMPORTANT: If you cannot read this letter in English or Español, you can call 1-844-393-6297 and ask for help to complete it and/or ask that this letter be translated to your language, at no cost to you.

Member Name (Last) (First)	Birth Date: Mo. Day Yr.	Effective Date of Enrollment: Mo. Day Yr.
(Address) (City) (State)		(ZIP Code)
Telephone (Home)	(Work)	Member ID #
Name of person completing form/relationship, if different from member		(Daytime Telephone)
Name of Optometrist or Ophthalmologist		Medical Group/Clinic
Where did the problem occur? (Name of Clinic)	Date of Incident: Mo. Day Yr	Time of Incident:
Inaccurate Directory? Yes ☐ No ☐		
Correct Address: Who was involved beside yourself ? (Give names of involved staff, if possible.)		Phone Number:
Who was involved beside yourself? (Give names of involved staff, if possible.)		

Please mail this completed form to:

EyeMax Vision Plan, Inc.
Attn: Grievance Dept.
P.O. Box 14227
Orange, CA 92863

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 **1-844-393-6297** 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 Web site **http://www.dmhc.ca.gov,** has complaint forms, IMR application forms, and instructions online.

Grievance Received By:	By Fax ☐	
	By Mail ☐	
Date Received:	By Telephone ☐	
Time Received:	Online ☐	

_____ _____

Member's Signature (optional) Date

I UNDERSTAND THAT TH E PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATIO N AND/OR ACTION

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DESCRIBE WHAT HAPPENED: (Please describe what happened as specifically as possible. Include the sequence of events and how the problem affected you).

ACTION REQUESTED: (What would you like to see done about this problem).

(Official Use Only)

OUTCOME/Resolution:

Acknowledgement sent within (5) days: ☐ Yes ☐ No sent by: _____

Member was acknowledged verbally and notified of the 72 hours appeal process: ☐ Yes ☐ No (Complete only if expedited Appeal)

Grievance Received by: _____ Date Received: _____