1333 Bush Street
San Francisco, CA 94109
415/292-8888
TTY: 711

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 Services Department will forward this form to the Chief Medical Officer or Senior Director of Health Plan Services. The appropriate officer will ensure this form is forwarded to an impartial third party for review.

Date: _____

To: On Lok PACE
Health Plan Services Department
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 PACE # 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

02-12-02 (rev. 01/20)

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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

For On Lok PACE Staff Use Only:

- ❑ On Lok PACE staff member who received the appeal:
  _____ Health Plan Services Department
  _____ Social Worker
  _____ Other, specify: _____
- ❑ Request received by the On Lok PACE staff member identified above: Date _____ Time _____
- ❑ Health Plan Services Department notified of the appeal by telephone or e-mail:
  Date _____ Time _____
- ❑ Health Plan Services Department sent a written acknowledgment to the participant: Date _____
- ❑ Health Plan Services Department telephoned acknowledgement of receipt to the participant:
  Date _____ Time _____
- ❑ Health Plan Services Department sent a written notification of the decision to the participant:
  Date _____ Time _____
- ❑ Health Plan Services Department telephoned notification of the decision to the participant:
  Date _____ Time _____