Oscar Grievance Form - California

We encourage the form to be completed and returned to Oscar to best assist you in resolving your grievance. However, completion of this form is optional. For a full list of methods to submit your grievance, please reference your Evidence of Coverage (EOC) or call Oscar's Member Services Department using the telephone number displayed on your member identification card.

1. Member Information:

Member Name: ________________________________ Member ID #: OSC________________________

Complainant/Appellant Name (if different from member): ____

Relationship to Member:____

Home Address:

____

City: ____ State: ___________ Zip: __________________

Home Phone Number: _________________________ Date of Birth: ____________________

2. To assist Oscar in reviewing your appeal or grievance, please summarize the issue and the action desired. Please attach all supporting documentation.

Is your issue regarding:

- ❏ Medication
- ❏ Medical Service or Equipment
- ❏ An issue not related to a specific medical service or medication
- ❏ A denial, reduction of or a failure to provide or make payment for services

For a specific medical service or medication, please provide the details:

Service or Medication: ____

Provider (Physician, Facility, Prescriber): ____

Service Date: ____

Claim ID(s): ____

Have you already received services?

❏ Yes ❏ No

PO Box 66550
Los Angeles, CA 90066

Please describe the nature of your grievance or appeal below (please use additional pages if necessary). Add any facts that you feel should be considered in the review of your grievance or appeal. As a reminder, please attach any supporting documentation that you have.

If you are the person who received the services and you want someone else to speak on your behalf, please complete the HIPAA authorization form and attach.

If you are attempting to submit an urgent appeal or grievance, that includes imminent danger to your life, life, or state of health, please contact 855-672-2755 to initiate an urgent appeal or grievance request.

3. Do you need to appoint a representative?

Skip this section if you are the member acting on behalf of yourself.

If you are not the member and aren't sure if you're authorized to work with Oscar on the member's behalf, please complete this section with the member.

I ______________________________________, appoint ____ to act on behalf of ____________________________________ in connection with any claim for coverage or benefits identified in this case including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan only in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

Member's Oscar ID Number: ____

Representative Name: _____________________________________

Relationship to Member: ________________________

Representative's Address:____

City: ____ State: __________ Zip: _______________

Representative Phone Number: _______________________________________

Did you speak with anyone at Oscar about this issue?
- ❑ Yes
- ❑ No

Is this grievance/complaint related to a terminal illness?
- ❑ Yes
- ❑ No

Are you facing imminent threat to your health or life, including but not limited to, severe pain, potential loss of life or major body function?
- ❑ Yes
- ❑ No

4. Signature and Submission

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this grievance. My failure to do so may result in Oscar closing the investigation related to this matter.

Signature: ____ Date: ______________

Name(Printed): ____

Please submit this completed form **(Attn: Grievances)** to one of the following:

By mail:
Oscar Insurance
PO Box 66550
Los Angeles, CA 90066

By email:
help@hioscar.com
Attn: Grievances

By fax:
888-977-2062
Attn: Grievances

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 **1-855-OSCAR-55** 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 **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.