HealthPartners

COMPLAINT/APPEAL FORM

We want to answer your questions and help resolve any problems you may have with your plan. Please complete this form if you would like to file a complaint with the health plan. Within five business days of receiving your signed form, we will send you written acknowledgement, including a phone number to call if you have questions. We will notify you of the outcome of our review within 30 days after we receive this form. If our decision is fully or partially adverse we will provide you at that time with the further options available to you. If you need help with this form or information about the process, please call Member Services at 952-883-5000 or 800-883-2177. **If you would like someone else to represent you in this request, please complete the attached authorization form.**

Member Name:_____ **Birth Date:** _____ **Member ID:**_____

Address: _____

Daytime Phone Number: _____ **May we leave a detailed message?** ☐ Yes ☐ No

If you have elected paperless communication, we'll send appeal information to your secure account on HealthPartners.com.

If you haven't elected paperless communication, we'll send appeal information to your email address, if you provide it below.

Email address: _____

I understand that typing my name in the line below constitutes a legal signature.

Member Signature: _____ **Date:** _____

Your Name: _____ **Relationship to Member:** _____

If you are not the member, they must complete and return the attached authorization form to allow you to represent them in this appeal.

Please describe your request. You can enclose any information you would like considered, such as comments, documents, records, etc., and use additional pages if needed to explain your request:

Date(s) of service and provider names, if any:

What specifically would you like to see happen to resolve this:

RETURN THIS FORM TO: **HealthPartners Appeals * 21104G * P.O. Box 1309 * Minneapolis, MN 55440-1309**

Email: DRT@HealthPartners.com - FAX: 952-883-9646

OTHER OPTIONS

In addition to the complaint process described above, at any time you have the right to contact a regulatory agency with your questions or concerns. If you have questions, please call Member Services.

Fully-Insured Minnesota-based health plan members: The agency varies based on your plan. HMO plan members may call the Minnesota Department of Health at (651) 201-5100 or (800) 657-3916 (toll free). Insurance plan members may call the Minnesota Department of Commerce at (651) 539-1600 or (800) 657-3602 (toll free).

Fully-Insured Wisconsin-based health plan members: At any time, you may file a complaint with The State of Wisconsin Office of the Commissioner of Insurance by calling (608) 266-0103 (Madison area) or 1-800-236-8517 to request a complaint form.

HealthPartners

Appointment of Authorized Representative For Written Complaint or Appeal

Fill out and sign this form to authorize someone else to act on your behalf for an appeal. Your authorized representative will have access to your protected health information as needed to represent you in this matter. This authorization will apply to all levels of appeal. **Information related to an appeal will be sent to your representative instead of to you.**

Member Name: _____ **Member Date of Birth:** _____

Member ID #: _____

Authorized Representative Information

The person you are authorizing to appeal on your behalf:

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone Number (with area code): _____

We will send appeal information to this person's secure HealthPartners account, if they have elected paperless communication. If they have not elected paperless communication, we will send it to their email address, if one is provided below.

Email address: _____

Appointment of Representative

I appoint the person listed above to act as my representative in connection with this written complaint or appeal for (**date of service/issue being appealed**): _____
I authorize this individual to make any request; to present or elicit evidence; to obtain complaint or appeal information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to this matter will be disclosed to my representative. This authorization applies only to the present complaint or appeal.

I understand that typing my name in the line below constitutes a legal signature.

Member Signature: _____ **Date:** _____

(Or signature of parent for minor child, or member's legal guardian)

Return this form to: HealthPartners Appeals, 21104G
PO Box 1309
Minneapolis, MN 55440-1309
Fax:952-883-9646
E-mail: DRT@HealthPartners.com

Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
HealthPartners follows Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of their race, color, national origin, age, disability or sex.

- We provide reasonable modifications to help people with disabilities communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

For Language or Communication Help:
Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our nondiscrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.
View this notice on our website at healthpartners.com.

To File a Grievance:
If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Español *(Spanish)*

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-883-2177 (TTY: 711) o hable con su proveedor.

Polski *(Polish)*

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-883-2177 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Deutsch *(German)*

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-883-2177 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

العربية *(Arabic)*

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل على الرقم 1-800-883-2177 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Lus Hmoob *(Hmong)*

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-883-2177 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

中文 *(Traditional Chinese)*

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-883-2177 (TTY: 711) 或與您的提供者討論。

Additional languages listed on page 2

Tagalog *(Tagalog)*

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-883-2177 (TTY: 711) o makipag-usap sa iyong provider.

Français *(French)*

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-883-2177 (TTY: 711) ou parlez à votre fournisseur.

Soomaali *(Somali)*

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-800-883-2177 (TTY: 711) ama la hadal bixiyahaaga.

اردو *(Urdu)*

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-883-2177 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

हिंदी *(Hindi)*

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-883-2177 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

РУССКИЙ *(Russian)*

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-883-2177 (TTY: 711) или обратитесь к своему поставщику услуг.

Việt *(Vietnamese)*

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-883-2177 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ગુજરાતી *(Gujarati)*

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલિરી સહાય અને ઍક્સેસિબિલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-883-2177 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

한국어 *(Korean)*

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-883-2177 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Afaan Oromoo *(Oromo)*

Hubachiisa: Yoo Afaan Oromo dubbatan, tajaajili gargaarsa afaan hiikuu tolaan ni jira. Gargaasi akkaan gaarii fi tajaajiloni kan biroo odeefannoo ittiin argatanis kafalttii malee ni kennamu. Lakkoofsa kanaan bilbilaa 1-800-883-2177 (TTY: 711) ykn Kan isin tajaajilan waliin haasawaa.

ထၢန်ၵ်လီ၊ဖဲအံၢ် *(Karen)*

ဆု- နမ့်၊ကတိၤ ထၢန်ၵ်လီ၊ဖဲအံၢ်၊ အယိ, တၢ်အိ၊ဉ်ဒီး ကျိ၊ဉ်တၢ်ဆိ၊ဉ်ထွဲမၤစၢၢ လၢတဲ့လၢ် ဘ့ဉ်လၢ်စ့ၢ်လၢနဂၤ်လီ၊. တၢ်အိ၊ဉ်ဒီး တၢ်မၤစၢၢတၢ်နၢ်ဟ့ပီးလီဒီး တ့ၢ်မၤစၢၢတၢ်မၤ လၢအကပြုအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လ့ၢတၢ်မၤနၢ်အီ၊ သ့တဖဉ် လၢတလၢ်ဘ့ဉ်လၢ်စ့ၢ် လၢနဂ့ၢ်လီ၊. ကိး 1-800-883-2177 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၢတက့ၢ်.

አማርኛ *(Amharic)*

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-883-2177 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

తెలుగు *(Telugu)*

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-800-883-2177 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Kiswahili *(Swahili)*

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-883-2177 (TTY: 711) au zungumza na mtoa huduma wako.