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.

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

Address: _____

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

May we send appeal information via messaging in your secure account on healthpartners.com? ☐ Yes ☐ No

Or may we send appeal information to your personal email address? ☐ Yes ☐ No

If yes, preferred email address: _____

Member (or Parent/Guardian) Signature: _____ **Date:** _____

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

If you would like someone else to represent you in this request, please complete the authorization form.

Your Request. Please enclose any information you would like considered, such as comments, documents, records, etc.

Please describe your request:

_____

_____

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

_____

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

_____

_____

Other comments:

_____

_____

RETURN THIS FORM TO:

HealthPartners Appeals * 21104G * P.O. Box 1309 * Minneapolis, MN 55440-1309
FAX: 952-883-9646 OR Email: DRT@HealthPartners.com

OTHER OPTIONS

For Fully-Insured Minnesota-based health plan members:

If you would like help with this form please call Member Services. In addition to the complaint process described above, at any time you have the right to contact a Minnesota regulatory agency with your questions or concerns. The agency varies based on your plan. If you have questions, please call Member Services. 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.

Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to 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 non-discrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@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. Llame al 1-800-883-2177. (TTY: 711)

Hmoob *(Hmong)*
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)

Tiếng Việt *(Vietnamese)*
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)

繁體中文 *(Chinese)*
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)

Русский *(Russian)*
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)

Af Soomaali *(Somali)*
OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)

ພາສາລາວ *(Laotian)*
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-883-2177. (TTY: 711)

Deutsch *(German)*
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)

العربية *(Arabic)*
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)

Français *(French)*
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)

한국어 *(Korean)*
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)

Tagalog *(Tagalog)*
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)

Additional languages listed on page 2
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Oromiffa *(Cushite [Oromo])*
XIYYEEFFANNAA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)

አማርኛ *(Amharic)*
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)

unD *(Karen)*
ဟ်သူၣ်ဟ်သး– နမ့ၢ်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူၣ်လၢာ်စ့ၢ် နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-800-883-2177. (TTY: 711)

ខ្មែរ *(Mon-Khmer, Cambodian)*
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)

Deitsch *(Pennsylvanian Dutch)*
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)

Polski *(Polish)*
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)

हिंदी *(Hindi)*
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)

Shqip *(Albanian)*
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)

Srpsko-hrvatski *(Serbo-Croatian)*
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)

ગુજરાતી *(Gujarati)*
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)

اُردُو *(Urdu)*
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-883-2177 (TTY: 711).

Italiano *(Italian)*
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)

ภาษาไทย *(Thai)*
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)

ελληνικά *(Greek)*
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)

Diné Bizaad *(Navajo)*
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló̜, kojį' hódíílnih 1-800-883-2177. (TTY: 711)

Ikirundi *(Bantu – Kirundi)*
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)

Kiswahili *(Swahili)*
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)

日本語 *(Japanese)*
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。

नेपाली *(Nepali)*
ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-883-2177 (टिटिवाइ: 711)

Norsk *(Norwegian)*
MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)

Adamawa *(Fulfulde, Sudanic)*
MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)

Українська *(Ukranian)*
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)

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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. Oral or written information related to an appeal will be sent to your representative instead of to you.

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

Member ID #: _____

Appointment of Representative

I appoint the person listed below to act as my representative in connection with this written complaint or appeal for (list 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.

Member Signature: _____ **Date:** _____

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

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): _____

May we send appeal information to this person's personal email address? ☐ **Yes** ☐ **No**

If yes, preferred email address: _____

Return this form to: HealthPartners Appeals, 21104G
PO Box 1309
Minneapolis, MN 55440-1309

You can also fax it to us at 952-883-9646 or email to DRT@HealthPartners.com