

Please complete the form, attach any additional information you want us to review, and return it to us.

- Complete Section I of the Complaint Form.
- If your request is beyond the 60 day Medicare or Medical Assistance (Medicaid) timeframe, complete Section II.
- Sign and date the Complaint Form (Section III).
- If you are a family member, friend or advocate of the member, please complete the enclosed Appointment of Representative form. Or you may attach appropriate legal documentation (example: Durable Power of Attorney). The Appointment of Representative form contains sections for both you and the member to complete. Please call us if you have any questions about this form. If you have already completed the Appointment of Representative form within the past year, you do not need to complete it again.
- Please contact Member Services if you are unable to complete the form yourself.

We'll send you a letter within ten business days of receiving your complaint. If you have any questions about these steps, please call Member Services or look in your Member Handbook. You may also call the State Managed Health Care Ombudsman regarding your question or concerns. A representative can help you file a State appeal. The numbers are 651-431-2660 or 1-800-657-3729. You may also contact the Minnesota Department of Health at 651-201-5100 or 1-800-657-3916.

For concerns regarding the quality of care you received, you may also file a complaint with the local Quality Improvement Organization (QIO):

Livanta BFCC-QIO Program

Phone: 866-815-5440

TTY: 866-868-2289

Time Frames

Your situation	Your deadline for submitting a complaint	Our deadline for reviewing your request and responding to you
You are appealing a coverage decision that we made for a Medicare Part A, Part B or C medical service (this is called an appeal)	Within 60 calendar days from the date on the written notice we sent (or explain why you missed the deadline – called ‘good cause’) – see Section II	Standard: within 30 calendar days of receiving your appeal Fast: within 72 hours of receiving your appeal if you haven’t had the service yet
You are appealing a coverage decision that we made for a Medicare Part B or Part D prescription drug (this is called an appeal)	Within 60 calendar days from the date on the written notice we sent (or explain why you missed the deadline – called ‘good cause’) – see Section II	Standard: within 7 days of receiving your appeal if you haven’t yet bought or received the drug (this is called pre-service) Part B and Part D prescription drug: Fast: within 72 hours of receiving your appeal if you haven’t received the drug yet (this is called pre-service) Part B prescription drug: Standard: within 30 calendar days of receiving your appeal if you have already bought or received the drug (this is called post-service) Part D prescription drug: Standard: within 14 calendar days of receiving your appeal if you have already bought or received the drug (this is called post-service)
You are appealing a coverage decision that we made for a Medical Assistance (Medicaid) covered service. This is called an Oral Appeal.	Within 60 calendar days from the date on the written notice we sent (or explain why you missed the deadline – called ‘good cause’) – see Section II If you appeal because we are changing or stopping a Medical Assistance (Medicaid) service you currently get, you have 10 calendar days to appeal if you want to keep getting that service while your appeal is processing	Standard: within 30 calendar days of receiving your appeal Fast: within 72 hours of receiving your appeal if you haven’t had the service yet
You are making a complaint about anything other than our decision related to benefits, coverage or payment (this is called a grievance)	There is no deadline.	Standard: within 30 calendar days of receiving your grievance Fast: within 24 hours if we denied your request for a fast appeal – we will do this automatically

8170 33rd Avenue South
P.O. Box 9463
Minneapolis, MN 55440-9463



HealthPartners Complaint Form

Member Full Name

Member ID Number

Member Address

Member Date of Birth

Member Phone Number

I. Please explain your issue or concern in detail. You may attach more pages if needed.

How can we resolve this problem?

II. Good Cause for missing the deadline for filing your complaint. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline.

If your request is beyond the 90 day time period, please explain the reason for the delay.

III. Please review and check one of the following boxes:

Permission to share: please review and check one of the following boxes:

I authorize HealthPartners to fully investigate this complaint in accordance with State and Federal guidelines. I also authorize the release of all information relating to this complaint (including all applicable billing and medical records). I understand that in the course of the review, HealthPartners may contact the providers involved to help resolve my complaint. This authorization is valid from the date signed until this complaint is fully resolved.

☐ I agree to allow HealthPartners to share my complaint with the providers involved.

☐ I do not want HealthPartners to share my complaint with the providers involved. I understand this may make it harder for HealthPartners to resolve this complaint.

Member or Representative Signature

Date

(If someone other than the member is signing, please complete and return the enclosed Appointment of Representative form or other legal documentation)

If you have any questions, we're here to help. Call us at 952-967-7029 or toll-free at 1-888-820-4285. If you use a TTY, please call 711.

From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative.

From **April 1 to Sept. 30**, call us 8 a.m. to 8 p.m. CT **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

Please mail this form to us at:
HealthPartners
P.O. Box 9463
Mail Stop 21103R
Minneapolis, MN 55440-9463
Fax: 952-853-8742



Civil Rights Notice

Discrimination is against the law. HealthPartners does not discriminate on the basis of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Auxiliary Aids and Services

HealthPartners provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** 1-866-885-8880.

Language Assistance Services

HealthPartners provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** 1-866-885-8880.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by HealthPartners. You may contact any of the following three agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- National Origin
- Disability
- Religion (in some cases)
- Color
- Age
- Sex

Contact the **OCR** directly to file a complaint:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Religion
- Creed
- Sex
- Sexual Orientation
- Marital Status
- Public Assistance Status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North
Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have a right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome period. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

HealthPartners Complaint Notice

You have the right to file a complaint with HealthPartners if you believe you have been discriminated against because of any of the following:

- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information
- Disability (including physical or mental impairment)
- Marital Status
- Age
- Sex (including sex stereotypes and gender identity)
- Sexual Orientation
- National Origin
- Race
- Color
- Religion
- Creed
- Public Assistance Status
- Political Beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
Office of Integrity and Compliance, MS 21103K
HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
1-844-363-8732 (toll free), 711 (TTY), 952-883-5522 (fax)
integrityandcompliance@healthpartners.com (email)

American Indian Health Statement

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

