FOR EYES VISION PLAN, INC.

2112 Shattuck Avenue
Berkeley, CA 94704
1-800-454-3937
1-510-843-2597 (Fax)

GRIEVANCE/COMPLAINT FORM

Please use this form for filing complaints and grievances or for making suggestions to For Eyes Vision Plan regarding its services, staff, products, offices, or any other aspect of For Eyes Vision Plan that affects you as a member. You may also file grievances, complaints, or suggestions verbally at any For Eyes Vision Plan location or by calling For Eyes Vision Plan's administrative office at **1-800-454-3937.** Should you choose to file a written grievance, complaint, or suggestion please type or print the information requested below and return this form to any For Eyes Vision Plan location or by mail or fax to the address/fax number listed above. Personnel at the administrative office and at each For Eyes Vision Plan location will be available to assist in the completion of this form. If necessary, for those with limited English proficiency is available without charge to assist in the submission and resolution of grievances.

For Eyes Vision Plan will acknowledge receipt of your grievance/complaint within five (5) days and will notify you of the status or resolution of your grievance/complaint in writing within thirty (30) days of the date the grievance/complaint was received by For Eyes Vision Plan.

If a complaint involves an imminent and serious threat to your health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, you may telephone For Eyes Vision Plan at the above number to obtain expedited review of your grievance/complaint. For Eyes Vision Plan will notify you and the Department of Managed Health Care with a written statement of the resolution or status of such complaint within three (3) days from the date the grievance/complaint was received.

MEMBER NAME _____

ADDRESS_____

CITY_____ ZIP_____

DAY TELEPHONE_____EVENING TELEPHONE_____

FOR EYES VISION PLAN LOCATION_____

PLEASE DESCRIBE THE FACTS OF YOUR COMPLAINT/GRIEVANCE:

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Signature and Date

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 **1 800 454-3937** 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 might be available to you. If you need help with a grievance involving any 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-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.