KOVA Healthcare, Inc.
Doctor focused patient centered.
7061 N. WHITNEY SUITE 102 FRESNO, CA 93720

Member Appeal or Grievance Form

At KOVA Healthcare, Inc. your concerns are important to us. If you disagree with a decision of requested services made about your health care, you can appeal that decision. If you want to file a complaint about care you received or how you were treated, you can file a complaint which is called a grievance. You can choose any of the following options to submit an appeal or grievance:

- Use this form
- Call KOVA Healthcare, Inc. Member Services at 559-207-3198 (For TTY, contact California Relay by dialing 711 and provide the Member Services number: 559-207-3198).
- Bilingual staff are available.
- Upon request, you can receive Member information materials in alternative formats including Braille, large print or audio.
- Fill out a form online at www.kovahealth.com
- Write a letter that includes the information below

You can choose someone to submit an appeal or grievance for you. We must have your written permission for that person to do so. Also, we may need your written permission to get medical records about your appeal or grievance. You can call Member Services at 559-207-3198 (For TTY, contact California Relay by dialing 711 and provide the Member Services number: 559-207-3198) or go to www.kovahealth.com to get the Authorized Representative Form and Medical Records Release Form.

Part 1: Member Information

First and Last Name:	Member ID #:	Date of Birth:
Address:	City:	Zip Code:
Phone Number:	Best Time to Call:	

Part 2: Information about the Appeal or Grievance

Please describe your issue or concern. Give us the details of what happened, when and who was involved. For Appeals: Attach a copy of the Notice of Action letter from KOVA Healthcare, Inc. .

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Part 3: For Your Information

If you wish to file a complaint or appeal a decision, the process used to resolve your complaint or appeal is called the Appeals and Grievance Process. Complaints can be filed at any time. Appeals must be filed within 60 calendar days from the date of Notice of Action. A Notice of Action is a formal letter sent to you by KOVA Healthcare, Inc. telling you that a medical service has been denied, delayed or modified.

If your appeal or grievance is urgent, you may ask for an "expedited review". Your appeal can be reviewed within 72 hours from the time it was received, if it involves an immediate and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Within five (5) calendar days of receipt of your request for an appeal or grievance, KOVA Healthcare, Inc. will send you an acknowledgement letter saying we received your request. The letter will also give you the name, address and phone number of the KOVA Healthcare, Inc. staff that will be handling your request and the date your request was received. Along with that letter, the staff will also send you information that describes the appeals and grievance process, outlines your rights in the process, provides information about the State Hearing process and provides addresses and phone numbers of local Northern California Legal Aid offices.

The appeals and grievance staff will try to get more information which may help us decide on a better resolution of your request. If necessary, the KOVA Healthcare, Inc. staff may contact you if she/he has any questions about your request if more information is needed.

You can contact the KOVA Healthcare, Inc. appeals and grievance staff to discuss your request. Within thirty (30) calendar days from the date of receipt of the request, the KOVA Healthcare, Inc. staff will mail a written letter that outlines KOVA Healthcare, Inc.'s resolution to your appeal or grievance.

You may, at any time, contact the government agency that regulates health care services plans regarding your grievance or appeal that KOVA Healthcare, Inc. has not resolved or has not resolved to your satisfaction.

California Department of Managed Health Care (DMHC)

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 (866) 255-4795 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-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.

Brand New Day

You have the right to submit an Appeal about the quality of care you received and/or reconsideration (appeal) when the Plan has made a coverage decision. If you don't believe you're receiving the services you're entitled to, or if you are being asked to pay more than what you believe, you can send an Appeal to Brand New Day through their website www.bndhmo.com or contact Brand New Day (866)255-4795 (TTY users 866-321-5955) or Fax (657)400-1217 Monday through Friday 8 a.m.- 8 p.m. Brand New Day will allow for a verbal request and will also accept appeals from an authorized representative acting on the members behalf. The members coverage will continue pending the outcome of the appeal.

Part 4: Signature

_____ _____
Signature of Member or Authorized Representative Date

_____ _____
Print Name of Member or Authorized Representative Date

Directions: Please fax this form or letter to 559-207-3901 or mail it to:

KOVA Healthcare, Inc.
Attention: Appeals and Grievances
7061 N. Whitney Ave Suite 102
Fresno, Ca. 93720

We will respond to your appeal or grievance within 30 days.