State of California - Health and Human Services Agency
Department of Managed Health Care
IMR APPLICATION/COMPLAINT FORM - ENGLISH
DMHC 20-224 New: 11/15 Rev: 01/23

INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION

You can submit your IMR Application/Complaint Form online at: www.HealthHelp.ca.gov

- **FREE:** The IMR/Complaint process is free.
- **FAST:** IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- **SUCCESSFUL:** Approximately **68** percent of patients receive the requested service through IMR.
- **FINAL:** Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name _____ Middle Initial __ Last Name _____

Patient's Date of Birth (mm/dd/yyyy) _____

Gender: ☐ Male ☐ Female ☐ Something Else _____

Name of Parent or Guardian if Filing for Minor Child _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Email Address _____

Would you like communication/correspondence sent to this email? ☐ Yes ☐ No

Health Plan Name _____ Patient's Membership # _____

Medical Group Name (if enrolled in a medical group) _____

Employer _____

Do you want someone to help you with your complaint? ☐ Yes ☐ No

If yes, please complete the attached 'Authorized Assistant Form.'

Do you have Medi-Cal? ☐ Yes ☐ No

If yes, have you filed a Request for a State Fair Hearing? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Do you want payment for a health care service that you already received? ☐ Yes ☐ No

If yes, list the date(s) of service, and the provider's name:

_____

YOUR HEALTH PROBLEM

(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services? ☐ Yes ☐ No

What is your medical condition or doctor's diagnosis (Please be specific) _____

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

_____

Did your health plan deny, delay or modify your treatment? ☐ Yes ☐ No

If yes, please check the reason given: (Check one)

☐Not Medically Necessary ☐Experimental or Investigational ☐Not an Emergency/Urgent
☐Not a Covered Benefit ☐Other (Please explain below)

_____

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

_____

Have you seen any out-of-network providers for your condition? ☐ Yes ☐ No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department's Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the Department to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Name (Print) _____

Patient or Parent Signature _____ Date _____

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken: _____

Would you like us to communicate/correspond with you in your primary language? ☐ Yes

Race/Ethnicity: _____

State of California - Health and Human Services Agency
Department of Managed Health Care
AUTHORIZED ASSISTANT FORM - English
DMHC 20-160 New: 04/06 Rev: 01/20

AUTHORIZED ASSISTANT FORM

- If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.
- If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print)_____

Patient Signature_____ Date_____

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)_____

Address_____

City_____ State_____ Zip_____

Relationship to Patient_____

Primary Phone #_____ Secondary Phone #_____

Email Address_____

☐ My power of attorney for health care decisions or other legal document is attached.

IMR Application/Complaint Form Instruction Sheet

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

Before You File:

In most cases, you must complete your plan's complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan's complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DEPARTMENT for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]
   OR
   Fill out and sign the IMR Application/Complaint Form.
2. If you want someone to help you with your IMR or complaint, complete the 'Authorized Assistant Form.'
3. If you have medical records from ***out of network*** *providers*, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.
4. You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The Department will obtain this information directly from your plan as part of the investigation.
5. If you are not submitting online, please mail or fax your form and any supporting documents to:

   Department of Managed Health Care Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center's possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

If it is determined that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

IMR Application/Complaint Form Instruction Sheet

The Information Practices Act of 1977 (California Civil Code Section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
- The Department's Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
- The Department may share your personal information, as needed, with the plan and providers who conduct the IMR.
- The Department may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the Department Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.