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Complaints, Grievance, and Appeals for California members

How to file a Grievance

Anthem Blue Cross has a formal process for reviewing member grievances and appeals. This process provides a uniform and equitable treatment of your grievance/appeal and a prompt response.

Anthem Blue Cross shall ensure that all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with visual or other communicative impairment. Such assistance shall include, but not be limited to, translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Definition of a Grievance

A grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a member or the member's representative. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Members have up to 180 calendar days from the date of an incident or dispute, or from the date the member receives a denial letter, to submit a grievance or appeal to Anthem Blue Cross

Standard Grievance/Appeal Review

Steps in the process

1. File your grievance or appeal with Anthem Blue Cross. You may also authorize someone to represent you. Authorization must be in writing. Call customer service for the authorization form. Your customer service number is on the back of your membership card.

   You can file your grievance or appeal by:
   a. Calling customer service. Your customer service number is on the back of your membership card.
   b. Mailing a letter or a completed grievance form which you can get on the website or by calling customer service or
   c. Submitting a grievance form online.

2. We will send you an acknowledgement letter within five (5) calendar days of receipt.

3. We will fully investigate your grievance/appeal, including all aspects of medical care involved. All medical records and/or responses that will assist with review of your case are requested. Clinical grievances/appeals are reviewed by staff medical personnel and physician specialists.. Non-medical grievances are reviewed by grievance specialists. We will provide a written response to you within 30 calendar days after we receive your grievance/appeal.

Expedited Review

The grievance system includes an expedited review process for urgent grievances and appeals. A grievance/appeal is expedited when a delay in decision-making may seriously jeopardize the life or health of a member or their ability to regain maximum function. This includes but is not limited to severe pain, potential loss of life, limb or major bodily function.

Steps in the process

1. File your request for an expedited grievance or appeal with Anthem Blue Cross using one of the methods listed in the standard

grievance process. You may also authorize someone to represent you. Authorization must be in writing. Contact customer service for the authorization form. Your customer service number is on the back of your membership card. Calling customer service is the recommended method for requesting an expedited review.

2. A physician will review your request and make a determination within 72 hours. If your request does not qualify for an expedited review, your grievance/appeal will be reviewed in the standard 30-day grievance process. You will be notified by mail if you do not qualify for expedited review.

3. There is no requirement that members participate in the health plan's grievance/appeal process prior to contacting the DMHC/CDI for assistance regarding an urgent (expedited) appeal.

Further Appeal Rights

If you are dissatisfied with our answer, you may be able to pursue one or more of the following appeal processes, depending on your situation and the appeal information contained in your Evidence of Coverage. If you need assistance please contact customer service at the number on the back of your membership card.

a. File a complaint with the Department of Managed Health Care (DMHC) provided that your Anthem Blue Cross health coverage is governed by them. **Click here for a link to the DMHC web site**. Your grievance acknowledgement letter and response letter from Anthem Blue Cross will include information on how to contact the Department of Managed Health Care.

If your health coverage is not governed by the DMHC, it may be governed by the Department of Insurance. Please contact customer service if you are not sure which entity governs your health coverage. Your customer service number is on the back of your membership card.
b. Submit a request for binding arbitration. Not all Anthem Blue Cross members may request binding arbitration. The right to request binding arbitration is explained in your Evidence of Coverage.
c. Request Independent Medical Review. Independent Medical Review is available for decisions to deny payment on the basis that the services are not medically necessary or that they are considered investigational or experimental. If your grievance involves a denial of health care service, information on the independent medical review process will be provided in our letters to you.
d. Have your case reviewed in an administrative hearing if you are a Medicare beneficiary or a MediCal enrollee. Those rights are identified in your Evidence of Coverage.
e. Seek legal remedies in a court of law.

FILE ONLINE GRIEVANCE

You will be redirected back to the member login page if you have not logged in yet.

GRIEVANCE FORMS:

GRIEVANCE FORM ENGLISH

GRIEVANCE FORM SPANISH: Formulario de quejas formales en español

GRIEVANCE FORM KOREAN: -

GRIEVANCE FORM VIETNAMESE: VIỆT - ĐƠN KHIẾU NẠI

GRIEVANCE FORM CHINESE: -

GRIEVANCE FORM TAGALOG: TAGALOG - FORM PARA SA KARAINGAN