Independent Medical Review (IMR)/Complaint Form

- FREE: The IMR/Consumer Complaint process is free.
- FAST: IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
- SUCCESSFUL: Approximately 60 percent of patients receive the requested service through IMR.
- FINAL: Health plans must follow the IMR decision and promptly provide the service.

Fields with an * are required.

Patient Information

First Name * Middle Initial Last Name *

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

Male Female Other

Name of Parent or Guardian if Filing for Minor Child:

First Name Middle Initial Last Name

Street Address *

City * State * CA Zip *

Primary Phone # *

Secondary Phone #

Email Address *

Would you like communication/correspondence sent to this email? *

Yes No

Health Plan Name * Kaiser

Patient's Membership # *

Medical Group Name (if in a medical group)

Employer

Do you want someone to help you with your complaint?
- If yes, please complete the attached 'Authorized Assistant Form.' *

Yes No

Do you have Medi-Cal? *

Yes No

- If yes, have you filed a Request for a State 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 dates(s) of service, and the provider's name: (500 character limit)

(500 characters remaining)

Your Health Problem

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, 500 character limit) *

Specify mental health and any comorbid condition(s) diagnosed at Kaiser by its mental health clinician(s).

(393 characters remaining)

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific, 500 character limit) *

Individual psychotherapy at a dose of ____-minute sessions, frequency of ___ session(s) per week, for an extended duration.

(377 characters remaining)

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 (explain below)

If other, please describe Network inadequacy-treatment unavailable in prescribed time frame

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition. (500 character limit)

Please list the following here:
1) Name and phone number of Kaiser therapist who prescribed treatment that cannot be timely provided;
2) Date that Kaiser therapist prescribed the treatment and indicated that it was not timely available at Kaiser

(255 characters remaining)

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 health 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. (2500 character limit) *

URGENT GRIEVANCE: Kaiser is unable to provide me with timely access to prescribed mental health care. On (ENTER DATE), I met with Kaiser mental health clinician, (ENTER NAME), who prescribed individual psychotherapy for me at a dose of (ENTER 45, 60, or 90)-minute sessions, frequency of ___ session(s) per week, for an extended duration. I was told that my individual treatment needs to begin urgently so that my life, health, and/or ability to regain maximum function are not jeopardized and/or so that I do not experience severe pain. However, I was also informed that timely access to mental health care for my condition is unavailable at Kaiser. The clinician submitted an urgent grievance to Kaiser on my behalf. Under SB855, Kaiser is obligated to immediately arrange for the prescribed care by a suitable and immediately available out-of-network provider.

(1635 characters remaining)

Attachments

Please use the form shown below to attach supporting documents.

Document Title

Browse for the file and click the "Attach Document" button. There is a 25MB size limit. Accepted Files: .pdf, .txt, .doc, .xls, .ppt, .gif, .jpg, .docx, .xlsx, .pptx

Choose File no file selected Attach Document

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.

I have read and agree to the Medical Release statement above. *

Statistical Information

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 Select a language

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

Yes No

Race/Ethnicity Select a race/ethnicity

Sign & Submit

By clicking "Sign and Submit" I declare that:

1. I am the person identified in the information above.
2. I am seeking Independent Medical Review with the Department of Managed Health Care.
3. The information entered above is correct to the best of my knowledge.
4. I understand that falsification of records or information submitted to the Department of Managed Health Care may subject me to administrative, civil, or criminal liability.

By checking the box below and clicking "Sign and Submit" I agree that the Department of Managed Health Care will consider me to have signed my application for Independent Medical Review.

Yes. I, _____, have read and agree to the "Sign and Submit" statement above.*

Sign & Submit Online