California Customer Grievance Form

To file your grievance, please follow these simple steps.

1. Read the grievance information at the end of this form.
2. Review your information and make changes if necessary.
3. Submit the form to complete the process.

If you have any questions about this form, please call customer service at 1.800.244.6224, or the toll-free number on your Cigna HealthCare ID card.

I am submitting a grievance to Cigna HealthCare of California, Inc. (Cigna HealthCare).

☐ Please check here if this case involves an imminent and serious threat to you or the health of the patient, including but not limited to, severe pain, the potential loss of life, limb, or major bodily function. If it does, please call Cigna HealthCare customer service at **1.800.244.6224 (Dial 711 (TTY)** for the hearing and speech impaired) or the toll-free number on your Cigna HealthCare ID card.

CUSTOMER INFORMATION (Customer to complete this information)			
Name (Last)	(First)	(Middle Initial)	Subscriber ID Number

Mailing Address (Street)	(City)	(State)	(Zip Code)

Daytime Telephone Number	Evening Telephone Number	☐ Please check here if you prefer **not** to be contacted by phone

Name of person filing the grievance (if other than customer) (Last)	(First)	(Middle Initial)

PATIENT INFORMATION (Complete only if patient is other than the customer)			
Name (Last)	(First)	(Middle Initial)	Subscriber ID Number

Mailing Address (Street)	(City)	(State)	(Zip Code)

Daytime Telephone Number	Evening Telephone Number	☐ Please check here if you prefer **not** to be contacted by phone

PROVIDER OR FACILITY INFORMATION (Please provide the name, phone number and address of any provider or facility referenced in this grievance)	
Provider or facility Name	Telephone Number

Provider or facility Address (Street)	(City)	(State)	(Zip Code)

Briefly outline the specific details of your grievance. Identify the grievance, and **when** the events you describe took place. If helpful, please provide **copies** of all itemized bills, checks (both sides) and correspondence related to this grievance. You can send this additional information to the following address or fax number.

Cigna HealthCare National Appeals
PO Box 188011
Chattanooga, TN 37422
Fax: 1.877.815.4827

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If this grievance involves a denial of treatment, services or supplies considered experimental for a terminal illness, and you would like to request a conference as part of the grievance process, please let us know below.

Have you sent any records, correspondence, or other concerns about this case to Cigna HealthCare customer service or anyone else connected with Cigna HealthCare? ☐ Yes ☐ No

If yes, please provide the contact information below (including phone or fax number, if available) and the date you sent the information.

CIGNA HEALTHCARE CONTACT INFORMATION	
Cigna HealthCare Contact Name (Last)	(First)
Cigna HealthCare Contact Telephone/Fax Number	Date

CERTIFICATION	
I certify that this information is true and correct.	
Signature	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 **1.800.244.6224 (Dial 711 (TTY) for the hearing and speech impaired) or the toll-free telephone number on your Cigna HealthCare identification card** 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 **(1.888.466.2219)** and a TDD line **(1.877.688.9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.