Appeal & Grievance Form

This form is for your use. You can file a grievance (complaint) or request an appeal regarding denied care/service or denied payment. GEMCare Health Plan **is required by law** to respond to your complaints and appeals. We have an outlined procedure exists for resolving these situations. If you have any questions, please feel free to call the Member Services department 661-716-8800, 877-697-2464 or via TDD/TTY 888-833-9312 for the hearing-impaired.

Please print or type the following information:

Member Name (Last, first, middle initial): ____

Member ID: ________________________________

Address: __________________________________ City, State, Zip ________________________

Home Phone number: _________________________ Cell Phone number: ____________________

Date of Birth: _________________________________ Gender: ☐ Male ☐ Female

Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" and provide the following information:

Name: ________________________________ Relationship to Member: _______________________

Address: __________________________________ City, State, Zip ________________________

Home Phone number: _________________________ Cell Phone number: ____________________

Please describe your ☐ complaint or ☐ appeal. It's helpful if you can give dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

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Please sign and MAIL or FAX TO the health plan:

By mail: **Fax:** 661-716-4810

GEMCare Health Plan, Appeals & Grievance Department, 4550 California Avenue, Ste. 100
Bakersfield, CA 93309

Federal Express:

GEMCare Health Plan, Appeals & Grievance Department, 4550 California Avenue, Ste. 100
Bakersfield, CA 93309

Date________________ **Signature**____

Date________________ **Signature of Representative**_______________________________