What is a complaint or grievance?

The terms "complaint" and "grievance" are used interchangeably for purposes of this form. A complaint or grievance is defined as an expression of dissatisfaction other than an appeal, as described below, relative to the Medi-Cal pharmacy benefit by a Medi-Cal beneficiary, an authorized representative (AR), or other interested party (e.g., someone filing a complaint anonymously). An inexhaustive list of examples includes, but is not limited to, dissatisfaction due to Medi-Cal Rx coverage policy, quality of care, timeliness of care, inaccuracies or omissions relative to services/information being provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or discriminatory practices pursuant to applicable state/federal law.[1]

Who should utilize this form and for what?

Medi-Cal beneficiaries receiving their pharmacy benefit through both the (regular) Medi-Cal fee-for-service (FFS) and Medi-Cal managed care delivery systems should use this form. This form should be utilized for complaints/grievances related to the Medi-Cal beneficiary's pharmacy benefit through Medi-Cal Rx.

When should this form not be used?

If you are a member of a Medi-Cal managed care plan (MCP) and your complaint is regarding your nonpharmacy-related services, such as your medical benefits, please contact your MCP's customer service center directly.

If you are a Medi-Cal beneficiary and your request is regarding an "appeal," which is defined as when a Medi-Cal beneficiary, AR, or other interested party disagrees with a pharmacy benefit- and/or eligibility-related decision, such as a coverage dispute (including disagreement with, and seeking reversal of, a Medi-Cal Rx Prior Authorization Request involving medical necessity), please utilize the existing State Fair Hearing (SFH) Process. You can also request an SFH online at the California Department of Social Services' publicly facing website (www.cdss.ca.gov).

[1] See Section 1557 of the Affordable Care Act (Title 45 Code of Federal Regulations Part 92) and Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017). Please note that complaints of alleged discrimination will be referred to the Department for Research and Resolution, according to existing internal processes and procedures.

How do I file a complaint or grievance with Medi-Cal Rx?

If you wish to file a complaint with the Medi-Cal Rx team, you can do so in the following ways:

- Call the **Medi-Cal Rx Customer Service Center** at (800) 977-2273.
- Log onto www.medi-calrx.dhcs.ca.gov to securely email a complaint.
- Mail this form to the following:

  Medi-Cal Rx Customer Service Center
  Attn: Complaints and Grievances Unit
  PO Box 730
  Rancho Cordova, CA 95741-0730

- Fax this form to the **Medi-Cal Rx Customer Service Center** at (800) 869-4325.

Complaints will be acknowledged within 1 day of receipt and processed within 30 calendar days.

Do you wish to remain anonymous? ☐ Yes ☐ No

(If checking "Yes," proceed to Page 3; if checking "No," please identify yourself below.

Are you the beneficiary? ☐ Yes ☐ No

Are you the parent or guardian if filing for a minor? ☐ Yes ☐ No

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____

City/State: _____ ZIP Code: _____

Are you the authorized representative? ☐ Yes ☐ No

If Yes, Your Name: _____

Your Phone Number: _____

Your Address: _____

_____

(If checking "Yes" as an authorized representative, please ensure that you have first filled out or attached the Authorized Representative Form available at www.medi-calrx.dhcs.ca.gov.)

Are you an "other interested party" filing on behalf of the beneficiary? ☐ Yes ☐ No

State who you are: _____

Beneficiary information for whom the complaint is filed (required)

Last Name: _____ First Name: _____ Middle Initial: ____

Patient's Date of Birth: _____

Medi-Cal ID (BIC) Number: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Describe in your own words what action(s) have happened that lead to your complaint:

_____

_____

_____

_____

_____

_____

Please indicate what resolution you are seeking:

_____

_____

_____

_____

_____

I declare under penalty of perjury that the information on this form is true and correct.

Beneficiary Signature: _____

Or Parent/Guardian Signature (for minors): _____

Or Authorized Representative Signature: _____

Or Other Interested Party Signature: _____

Date: _____