HealthPartners®
8170 33rd Avenue South
P.O. Box 9463
Minneapolis, MN 55440-9463

Dear HealthPartners Robin Member:

Thank you for sharing your concerns with us. I have enclosed a Complaint Form. Please complete the form, attach any additional information you want us to review, and return it in the enclosed envelope.

- Complete Section I of the Complaint Form.
- If your request is a beyond the 60 day Medicare timeframe, complete Section II.
- Sign and date the Complaint Form (Section III).
- If you are a family member, friend or advocate of the member, please complete the enclosed Appointment of Representative form. Or you may attach appropriate legal documentation (example: Durable Power of Attorney). The Appointment of Representative form contains sections for both you and the member to complete. Please call us if you have any questions about this form. If you have already completed the Appointment of Representative form within the past year, you do not need to complete it again.
- Please contact Member Services if you are unable to complete the form yourself.

We'll send confirmation within ten business days of receiving your complaint. If you have any questions about these procedures, please call Member Services or consult your Evidence of Coverage.

For concerns regarding the quality of care you received, you may also file a complaint with the local Quality Improvement Organization (QIO):

Livanta

Call 888-524-9900

TTY 888-985-8775

Write Livanta LLC

BFCC-QIO

10820 Guilford Road, Suite 202

Annapolis Junction, MD 20701-1105

Website livantaqio.com

Time Frames

Your situation	**Your deadline** for submitting a complaint	**Our deadline** for reviewing your request and responding to you
You are appealing a coverage decision that we made for a Medicare Part A, Part B or C **medical service** (this is called an **appeal**)	Within 60 calendar days from the date on the written notice we sent (or explain why you missed the deadline – called 'good cause') – see Section II	Standard: within 30 calendar days of receiving your appeal Fast: within 72 hours or receiving your appeal if you haven't had the service yet
You are appealing a coverage decision that we made for a Medicare Part B **prescription drug** (this is called an **appeal**)	Within 60 calendar days from the date on the written notice we sent (or explain why you missed the deadline – called 'good cause') – see Section II	Standard: within 7 days of receiving your appeal if you haven't yet bought or received the drug (this is called pre-service) Part B prescription drug: Fast: within 72 hours of receiving your appeal if you haven't received the drug yet (this is called pre-service) Part B prescription drug: Standard: within 30 calendar days of receiving your appeal if you have already bought or received the drug (this is called post-service)
You are making a complaint about anything other than our decision related to benefits, coverage or payment (this is called a **grievance**)	Within 60 calendar days from the date that you had the problem (or explain why you missed the deadline – called 'good cause') – see Section II	Standard: within 30 calendar days of receiving your grievance Fast: within 24 hours if we denied your request for a fast appeal – we will do this automatically

If you have any questions, we're here to help. Call us at 866-233-8734.

If you use a TTY, please call 711.

From Oct. 1 through March 31, we take calls from 8 a.m. to 8 p.m. CT, seven days a week. You'll speak with a representative.

From April 1 through Sept. 30, call us 8 a.m. to 8 p.m. CT Monday through Friday to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

Sincerely,

Member Services

Enclosures: HealthPartners Complaint Form & Return Envelope
Appointment of Representative Form

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8170 33rd Avenue South
P.O. Box 9463
Minneapolis, MN 55440-9463

HealthPartners Complaint Form

Member Name & Address:	Member ID Number: Date of Birth: Phone Number:

I. Please explain your issue or concern in detail. You may attach more pages if needed.

How can we resolve this problem?

II. Good Cause for missing the deadline for filing your complaint. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline.

If your request is beyond the 60-day time period, please explain the reason for the delay.

III. Permission to share: please review and check one of the following boxes:

I authorize HealthPartners to fully investigate this complaint in accordance with State and Federal guidelines. I also authorize the release of all information relating to this complaint (including all applicable billing and medical records). I understand that in the course of the review, HealthPartners may contact the providers involved to help resolve my complaint. This authorization is valid from the date signed until this complaint is fully resolved.

☐ I agree to allow HealthPartners to share my complaint with the providers involved.

☐ I do not want HealthPartners to share my complaint with the providers involved. I understand this may make it harder for HealthPartners to resolve this complaint.

Member or Representative Signature Date

(If someone other than the member is signing, please complete and return the enclosed Appointment of Representative form or other legal documentation)

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Please mail this form in the enclosed envelope or send it to us at:

HealthPartners Member Rights & Benefits

P.O. Box 9463

Mail Stop 21103R

Minneapolis, MN 55440-9463

Fax: 952-853-8742