8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440

HealthPartners®

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 or Medical Assistance (Medicaid) 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 you a letter within ten business days of receiving your complaint. If you have any questions about these steps, please call Member Services or look in your Member Handbook. You may also call the State Managed Health Care Ombudsperson regarding your question or concerns. A representative can help you file a State appeal. The numbers are 651-431-2660 or 1-800-657-3729. You may also contact the Minnesota Department of Health at 651-201-5100 or 1-800-657-3916.

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

Livanta BFCC-QIO Program

Phone: 866-815-5440

TTY: 866-868-2289

HealthPartners is an HMO SNP plan with a Medicare contract and a contract with the Minnesota Medical Assistance (Medicaid) program. Enrollment in HealthPartners depends on contract renewal.

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 of 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 or Part D **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 and Part D 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) Part D prescription drug: Standard: within 14 calendar days of receiving your appeal if you have already bought or received the drug (this is called post-service)
You are appealing a coverage decision that we made for a Medical Assistance (Medicaid) covered service. This is called an Oral 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 If you appeal because we are changing or stopping a Medical Assistance (Medicaid) service you currently get, you have 10 calendar days to appeal if you want to keep getting that service while your appeal is processing	Standard: within 30 calendar days of receiving your appeal Fast: within 72 hours of receiving your appeal if you haven't had the service yet
You are making a complaint about anything other than our decision related to benefits, coverage or payment (this is called a **grievance**)	There is no deadline.	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

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RVSC_CLOSING_MSHO

Sincerely,

USER_SIGNATURE
Member Services

Enclosures: HealthPartners Minnesota Senior Health Options (MSHO) Complaint Review Form & Return Envelope

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

HealthPartners Complaint Form

Member Full Name

Member ID Number

Member Address

Member Date of Birth

Member Phone Number

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

How can we resolve this problem?

HealthPartners is an HMO SNP plan with a Medicare contract and a contract with the Minnesota Medical Assistance (Medicaid) program. Enrollment in HealthPartners depends on contract renewal.

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.

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III. Please review and check one of the following boxes:

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)

If you have any questions, we're here to help. Call us at 952-967-7029 or toll-free at 1-888-820-4285. 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 to 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.

Please mail this form in the enclosed envelope or mail to:
HealthPartners
P.O. Box 9463
Mail Stop 21103R
Minneapolis, MN 55440-9463
Fax: 952-853-8742

HealthPartners is an HMO SNP plan with a Medicare contract and a contract with the Minnesota Medical Assistance (Medicaid) program. Enrollment in HealthPartners depends on contract renewal.

Civil Rights Notice

Discrimination is against the law. HealthPartners does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by HealthPartners. You may file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator, MS 21103K
Office of Integrity and Compliance
HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309

1-844-363-8732 (toll free)
711 (TTY)
952-883-5522 (fax)
integrityandcompliance@healthpartners.com (email)

Auxiliary Aids and Services

HealthPartners provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** 1-866-885-8880.

Language Assistance Services

HealthPartners provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** 1-866-885-8880.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by HealthPartners. You may also contact any of the following agencies directly to file a discrimination complaint:

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Customer Response Center:
800-368-1019 (toll free)
800-537-7697 (TTY)
ocrmail@hhs.gov (email)

istance

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North
Suite 201
St. Paul, MN 55104

651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- religion (in some cases)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

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1-866-885-8880 (TTY:711)

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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