State of California
Health and Human Services Agency
Department of Managed Health Care
REQUEST FOR HEALTH PLAN INFORMATION (RHPI)
DMHC 20-097 New: 01/00 Rev: 11/25

Health Plan to Complete All Items

1. At the time relevant to the complaint, was the health plan product Knox-Keene regulated?
   ☐Yes ☐No
   a. If no, state the regulating entity if known. The health plan need only complete questions #1 through #4. ☐CDI ☐DOL ☐DHCS ☐CMS ☐OPM ☐Other:_____
   b. If yes, please provide the following information and complete the rest of the form:

   Member Name:_____ Subscriber Name:_____

   Member ID Number:_____ Medical Group/IPA:_____

   Member Date of Birth:_____

2. Product name:_____
3. Enrollment Type: Check all coverage types that are applicable to the complaint.

<u>Commercial</u>

☐HMO Large Group
☐HMO Small Group On Exchange
☐HMO Small Group Off Exchange
☐HMO Individual On Exchange
☐HMO Individual Off Exchange

☐POS Large Group
☐POS Small Group On Exchange
☐POS Small Group Off Exchange
☐POS Individual On Exchange
☐POS Individual Off Exchange

☐PPO Large Group
☐PPO Small Group On Exchange
☐PPO Small Group Off Exchange
☐PPO Individual On Exchange
☐PPO Individual Off Exchange

☐EPO Large Group
☐EPO Small Group On Exchange
☐EPO Small Group Off Exchange
☐EPO Individual On Exchange
☐EPO Individual Off Exchange

<u>Government</u>

☐Medi-Cal Managed Care
☐Medicare Advantage
☐Medicare Fee-for-Service
☐Medicare Supplement
☐Medicare Part D Only
☐Federal Employee Health Benefits (FEHB) Program

<u>Other</u>

☐Administrative Services Only (ASO)
☐Discount
☐In Home Supportive Services (IHSS)
☐Employee Assistance Program (EAP)
☐Other (please specify):_____

4. Group Enrollment Subtype: Check all that apply.

☐CalPERS ☐COBRA ☐Self-Insured ERISA
☐Multi-State Plan ☐Cal-COBRA ☐Self-Insured Non-ERISA

5. At the time relevant to the complaint, was the service-rendering provider(s) in-network? ☐Yes ☐No ☐N/A
6. Does the member bear any financial responsibility for services denied coverage? ☐Yes ☐No ☐N/A
    a. If yes, is there a valid waiver signed by the member? ☐Yes ☐No
        i. If yes, please provide a copy of the signed waiver.
7. For Medi-Cal members: State Fair Hearing filed? ☐Yes ☐No
    a. If yes, date(s) scheduled or completed:_____
8. For Medicare-Medi-Cal (Dual Eligibles): CMS Reconsideration appeal completed? ☐Yes ☐No
9. Grievance Information: For each distinct issue raised by the member in the complaint, please provide the grievance information below **as available and applicable**.
    1) The date(s) each grievance associated with the complaint were received and resolved. Include whether the grievance was expedited.
    2) The category of grievance in the health plan's grievance system (Cal. Code Regs., tit. 28, § 1300.68(e)(2)), including coverage disputes, medical necessity disputes, experimental/investigational disputes, quality of care, access to care, quality of service, claims/financial disputes, enrollment disputes, or other disputes. If the complaint has not gone through the Plan's grievance process, please put "N/A".
    3) If the complaint has an associated prior authorization, authorization, or claim: provide the associated procedures, services, supplies, (e.g., CPT, HCPCS, or CDT codes) and/or medications.
    4) If the complaint has an associated prior authorization, authorization, or claim: provide the associated diagnoses (e.g., ICD codes).

#	Date(s) Grievance Received	Date(s) Grievance Resolved	Exp? (Y/N)	Grievance Category (Access, Medical Necessity, etc.)	Procedures, Services, Supplies (CPT, HCPCS, CDT) or medications	Diagnoses, Nature of Illnesses, or Injuries (ICD)
1						
2						
3						

10. Requested Complaint/Independent Medical Review resolution (check all that apply):

☐ **IMR**. Please check the basis for denial (check only one):

☐ Medical Necessity ☐ Experimental / Investigational ☐ Dental Necessity

☐ ER / Urgent Care Reimbursement ☐ Cosmetic/Not Reconstructive Surgery

☐ **Grievance based on coverage dispute**. Plan agrees Department should review as a complaint. If the health plan asserts the requested service is not a covered benefit, please set forth the basis for this position including relevant references to statute(s), regulation(s), and/or EOC provision(s).

☐ **Grievance based on quality of care or quality of service**. Plan agrees to refer the member's concerns to its quality assurance program for further investigation.

☐ **Plan Decision Reversed or Approved**. If the health plan has reversed its prior decision, or approved the request through the Grievance process, provide a copy of the written resolution addressing each of the member's issues, include the reasoning why the health plan is now reversing the plan's decision. **If applicable**, please describe what the plan relied upon when reviewing the documentation sent by the DMHC that led to the plan's reversal.

☐ **RTP**. Plan is requesting the complaint/independent medical review request be returned to the health plan (RTP), mark the reason for the RTP:

☐ Member has not completed the Knox-Keene grievance process. Date process will be completed: _____. Provide copies of the member's written or verbal (telephone log) grievance, the health plan's grievance acknowledgement letter (if grievance has already been under health plan review for more than five days), any and all medical records related to the disputed service, and any additional related correspondence between the health plan and the member.

☐ Medi-Cal Member has not completed the adverse benefit determination appeal process. Date process will be completed: _____. Provide copies of the member's written or verbal (telephone log) request for service, the health plan's grievance acknowledgement letter (if grievance has already been under health plan review for more than five days), any and all medical records related to the disputed service, and any additional related correspondence between the health plan/provider and the member.

☐ Other. (Please Explain) _____

The health plan's response is a submission to the Department Director pursuant to Health and Safety Code section 1396.

Health Plan Representative's Name:_____

Health Plan Representative's Title:_____

Contact Phone:_____ Fax Number:_____

Contact E-mail Address:_____

Should the health plan be unable to completely respond to the Department's request by the deadline, please describe the action(s) being taken to obtain the requested information and/or records and when receipt is expected. (Cal. Code Regs., tit. 28, § 1300.68(g)(6).)

The health plan's failure to timely provide the requested information or fully explain the reason for the delay may be considered by the Department as evidence in favor of the member's position. (Cal. Code Regs., tit. 28, § 1300.68(h).)

HEALTH PLAN INSTRUCTIONS

If the health plan has not changed its position and the issues raised by the member have not been resolved:

Provide the following additional information:

- A written response that fully addresses all issues raised in the complaint.
- Copy(ies) of the member's grievance(s) submitted to the health plan as well as copy(ies) of the health plan's grievance response(s) sent to the member.
- A complete and legible copy of all medical records related to the complaint. This includes ancillary records such as ambulance transport records. The health plan shall inform the Department if medical records were not used by the health plan in resolving the complaint.
- A complete copy of the member's Evidence of Coverage (EOC) with the specific applicable sections identified. If the health plan relied solely on the EOC, the plan shall notify the Department of this fact.
- All other information used by the health plan or relevant to the resolution of the complaint, including but not limited to the following:
    - All written correspondence, including letters, denial letters, and e-mails, between the health plan, medical group, provider, or member;
    - Telephone logs or other documentation of telephone communication between the health plan, medical group, provider, or member;
    - Any health plan or medical group medical policies, clinical criteria, or coverage policies relating to the dispute;
    - Any outside clinical or coverage review obtained by the health plan in resolving the complaint, including any utilization management determination made by an outside organization, or medical group; and
    - Internal notes of the health plan, medical group, or provider reflecting the handling of the member's dispute.

If the subject member is enrolled in a Multi-State Plan (MSP), the health plan is directed to provide all information outlined above in response to this request. The health plan may include any position it wishes to take with respect to jurisdiction within its written response.