Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

NOTICE OF GRIEVANCE RESOLUTION

Date: Click or tap here to enter text.

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: YOUR GRIEVANCE

You or Name of requesting provider or authorized representative, on your behalf, filed a grievance with the Plan on DATE. Plan has reviewed your grievance. This notice describes steps taken to resolve your grievance.

Using plain language, insert: 1. A summary of the grievance filed by the beneficiary; 2. Steps taken to resolve the grievance (e.g., investigation, speaking with provider); 3. A clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the beneficiary; and, 4. The reasons for the decision.

If you are dissatisfied with the resolution of your grievance, you may file another grievance with the Plan.

The Plan can help you with any questions you have about this notice. For help, you may call Plan hours of operation at 24/7 toll-free telephone number. If you have trouble hearing or speaking, please call TTY/TTD: 711, between hours of operation for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact Plan by calling telephone number.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609

Signature Block

Enclosed: Your Rights
Language Assistance Notice
Beneficiary Non-Discrimination Notice