Grievance and Appeal Form for Members enrolled in:

Families and Children (PMAP), Minnesota Senior Care Plus (MSC+), MinnesotaCare, SingleCare (SNBC), or SharedCare (SNBC)

Grievance: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

Appeal: A way for you to challenge our action if you think we made a mistake and you do not agree with our decision. (Example: asking us to change our mind about denying a prior authorization request or a coverage determination request for a service.)

For more information about your rights and the grievance or appeal processes, please read Section 13 of your Member Handbook, or call Member Services at the number listed below.

Please complete this form to the best of your ability and return it by mail, fax, or by hand delivery. If you have any questions while completing this form, call Member Services at the number listed below.

South Country Health Alliance
Grievance and Appeals 2300
6380 West Frontage Road
Medford, MN 55049

Fax: 507-444-7774

Phone: 1-866-567-7242
TTY users call 1-800-627-3529 or 711.

Hours: 8 a.m. to 8 p.m., Monday - Friday

Section 1: Important Information Regarding a Grievance or Appeal
According to state guidelines, you have 60 days from the date of notice of agency action (e.g. denial notice) to file an appeal request. We are unable to consider appeals received after 60 days unless there is a valid reason for the delay. Grievances can be filed at any time. If you are not submitting your appeal request in a timely manner, please state the reason why the appeal is late:

Section 2: Member Information		
Member Name:		Date of Birth:
Member Address:		
City:	State:	Zip:
Phone Number:	SCHA ID Number:	

Section 3: Grievance or Appeal Information	
Involved Provider's Name:	
If the service has already occurred, please enter the **Date(s) of Service:**	
Type of Service:	
If this is a claim denial (denial of payment for a service completed), provide the claim number. You can find it on the bill you may have received.	Provider Claim Number:

Section 4: Description of your Grievance or Appeal
If filing a *grievance,* please explain what happened; if filing an *appeal*, please include the reasons you feel our decision should be changed. You may also include any other evidence, such as bills, letters or records to support your explanation. *(Use another sheet if you need more room to write.)*

Section 5: Signature	
Signature:	Date:
Print Name:	
☐ I am a provider.	
Only a member or their authorized representative can file a grievance/appeal with South Country Health Alliance. If the person submitting this form is someone other than the member, please complete section 6. Providers filing an appeal of a Prior Authorization denial do NOT need member consent to file (please check the box in section 5 that shows you are a provider).	

Section 6: Documentation of a Valid Representative	
Name of Authorized Representative:	
☐ I am already on file with South Country Health Alliance as a representative for member.	☐ I have included documentation of my authorized representative status for member.
Representative Phone Number:	Representative Mailing Address:

Section 7: Additional Information
For additional assistance or information, contact the Ombudsperson for Managed Health Care Programs at 1-800-657-3729 or 651-431-2660 (Metro), TTY users call 1-800-627-3529 or 711.
For complaints against a facility, you may call Minnesota Department of Health at 1-800-657-3916, TTY users call 1-651-201-5797

1-866-567-7242, TTY 1-800-627-3529 or 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.

ဟ်သူဉ်ဟ်သးဘဉ်တကွၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လိတဲစီနီၢ်ဂ်ၢ်လၢထးအံၤနူဉ်တကွၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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.

Civil Rights Notice

Discrimination is against the law. South Country Health Alliance (South Country) 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 South Country. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
South Country Health Alliance
6380 West Frontage Road, Medford, MN 55049
Toll Free: 866-567-7242 TTY: 800-627-3529 or 711 Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

Auxiliary Aids and Services: South Country 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** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

Language Assistance Services: South Country 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** Member Services at members@mnscha.org or call 866-567-7242, TTY 800-627-3529 or 711.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by South Country. 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, TTY: 800-537-7697
Email: ocrmail@hhs.gov

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

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