EYEXAM℠
OF CALIFORNIA

**SUGGESTION/COMPLAINT FORM**

**INSTRUCTIONS:**

Please use this form for filing complaints or grievances, or for making suggestions relating to your EYEXAM Plan, it's services, personnel, offices, or any other aspect of the Plan that affects you as a member.

1. Please type or print the information requested below.

2. Return this form by mail to: EYEXAM of California, Inc.
   P.O. Box 2756
   Mission Viejo, CA 92690
   www.eyexamofca.com

3. You will receive a written acknowledgement or receipt within five (5) days, And usually, a complete response will be made within thirty (30) days.

4. If you need assistance or have questions regarding the grievance process, please call EYEXAM at 1-888-439-3392. The Plan also has a TDD line 1-949-364-1289 for the hearing impaired.

MEMBER NAME: _____
Last First Initial

MEMBER ADDRESS: _____

_____

MEMBER TELEPHONE: _____

_____

GROUP I.D. NUMBER: _____

_____

TYPE OF MEMBERSHIP: Individual ( ) Group ( )

If Group, name of Group: _____

If you are completing this form on behalf of the EYEXAM member, please give your name, Relationship to the Member, address and telephone number below:

Name/Relationship: _____

Address: _____

Telephone: _____

SUGGESTION OR COMPLAINT: (Please include the details leading to your suggestion or complaint, such as the date, location and names or others involved.)

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Signature of Member or Representative Date

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(888) 439-3392** and use your health plan's grievance process before contacting the department. The Plan also has a TDD line **(949) 364-1289** for the hearing impaired. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.