Dental Benefit Providers of California
A UnitedHealth Group Company

California Language Assistance Program Summary Page

The legislation outlines specific requirements of the plans and the contracted network when working with LEP members. Detailed information about these requirements can be found on the California Department of Managed Health Care (www.dmhc.ca.gov) Web site.

The DBP-CA Language Assistance Program includes:

- ☐ Surveying members to determine language preferences
- ☐ Making the information collected about members' language preferences available to network clinicians and facilities upon request via customer service representatives
- ☐ Informing members and providers of the availability of free language services. Providing information to members on the availability of bilingual clinicians in the online Provider Directory
- ☐ Free interpreter services in the caller's language of choice via the Language Line to any member who requires language assistance by calling the customer service number on the back of the members' ID card
- ☐ Written DBP-CA member documents interpreted via the Language Line, for all relevant documents according to the regulations
- ☐ Written translation of member documents will be provided if spoken interpretation is refused

What is required of clinicians and facilities?

- ☐ Offer free interpretation services through DBP-CA to members with LEP, even when the member is accompanied by a family member or friend who can interpret.
- ☐ Document the acceptance or denial of interpreter services in the member's treatment record.
- ☐ Make the DMHC's grievance process and Independent Medical Review (IMR) application and instructions available to member upon request. Providers may access the DMHC grievance instructions and IMR application on the Department's Web site at www.dmhc.ca.gov. The IMR application and instructions are available in more than 10 languages.
- ☐ Go to DBP.com to obtain the pre-translated versions of the grievance form in each threshold language as well as the English version, accompanied by the notice of availability of language assistance. The Web site will be updated prior to January 1, 2009. You may also contact us to obtain a paper copy for the member by calling the number on the back of the member's ID card.
- ☐ If language assistance is required, contact DBP-CA at the number provided on the back of the member's ID Card. You will then be connected with the Language Line, via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.
- ☐ DBP-CA will be monitoring provider compliance with the language assistance program in 2009, as required by the regulations, through site visits and chart reviews.

Dental Grievance Form
Formulario de Quejas

Please complete and return this form to the mailing address shown below at your earliest convenience. Receipt from you will be acknowledged within 5 calendar days, and you will be notified of the resolution within 30 calendar days. Thank you for your cooperation.

Por favor llene y regrese este Formulario lo más pronto posible a la dirección que aparece abajo. Le avisaremos en cinco días del dia que recibimos su formulario, y le haremos saber la resolución en 30 días. Gracias por su cooperación.

MEMBER INFORMATION
INFORMACIÓN DEL MIEMBRO

Member Name
Nombre del Miembro

Identification #
 # de Identificación

Patient Name (if applicable)
Nombre del Paciente (si es aplicable)

Member Address
Dirección del Miembro

Apt #
 # de Apt

City
Ciudad

State
Estado

Zip Code
Código Postal

Day Phone #
Telefono de Día

Evening Phone #
Telefono de Noche

Email Address
Dirección del Email

PROVIDER INFORMATION
INFORMATCIÓN DEL DENTISTA

Provider Name
Nombre del Dentista

Provider Address
Dirección del Dentista

City
Ciudad

State
Estado

Zip Code
Código Postal

Date of First Visit
Fecha de la Primera Visita

Date Problem Occurred
Fecha en que Ocurrió el Problema

DESCRIBE YOUR GRIEVANCE (PROBLEM)
DESCRIBA SU QUEJA (PROBLEMA)

Please attach additional sheet if necessary
Por favor agregue una hoja adicional si es necesario

If you talked with the Provider office and/or plan personnel about this matter, please list their name(s)
Si usted habló con el dentista y/o con el personal del plan acerca de este asunto, por favor escriba sus nombres aqui

I hereby certify that this information is true and correct to the best of my knowledge
Yo certifico que esta información es verdadera y correcta según mi leal saber y entender

X _____

Member Signature
Firma del Miembro

Date
Fecha

Mailing Address: Grievances and Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569

Phone: 1-800-445-9090

PDVCA1283-001

EXPEDITED REVIEW

The Plan makes every effort to process your appeal as quickly as possible. In some cases, you have a right to an expedited 72- hour appeal if your health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to 30 days. You may file an oral or written request for a 72-hour appeal. Call, write or fax the Plan. Ask for an "expedited review," a "72-hour review," or say, "I believe my health could be seriously harmed by waiting for a standard review."

Call:

1-800-445-9090 (5 a.m. – 8 p.m. Pacific)
TTY 711

Write:

Grievances and Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

Or Fax:
(714) 364-6266.

FOR ALL CALIFORNIA MEMBERS

If a complaint has been sent for immediate expedited review, the Plan will immediately inform you in writing of your right to notify the Department of Managed Health Care of the grievance. The Plan will provide you and the Department of Managed Health Care with a written statement of the disposition of pending status of the expedited review no later than three days from receipt of the complaint.

The following language is required by the Department of Managed Health Care:

"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 **1-800-445-9090** or **TTY 711** and use your health plan's grievance process before contacting the department. 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-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."

Dental Grievance Form
牙科申訴表

Please complete and return this form to the mailing address shown below at your earliest convenience. Receipt from you will be acknowledged within 5 calendar days, and you will be notified of the resolution within 30 calendar days. Thank you for your cooperation.

請在您方便時儘快填妥本表格並寄回以下地址。您會在 5 個曆日內收到確認收件函，並在 30 個曆日內接到解決通知。感謝您的合作。

MEMBER INFORMATION
會員資訊

Member Name
會員姓名

Identification #
會員卡號碼

Patient Name (if applicable)
病患姓名 (如適用)

Member Address
會員地址

Apt #
門牌號碼

City
城市

State
州

Zip Code
郵遞區號

Day Phone #
日間電話號碼

Evening Phone #
夜間電話號碼

Email Address
電子郵件地址

PROVIDER INFORMATION
醫療服務提供者資訊

Provider Name
醫療服務提供者姓名 / 名稱

Provider Address
醫療服務提供者地址

City
城市

State
州

Zip Code
郵遞區號

Data of First Visit
第一次看診資料

Date Problem Occurred
問題發生日期

DESCRIBE YOUR GRIEVANCE (PROBLEM)
描述您的申訴 (問題)

Please attach additional sheet if necessary
如有需要，請另外加頁。

If you talked with the Provider office and/or plan personnel about this matter, please list their name(s)
如果您和醫療服務提供者診所和 (或) 本計畫人員討論過此事，請列出其姓名。

I hereby certify that this information is true and correct to the best of my knowledge
我在此證明，以上資訊盡我所知正確無誤

X

Member Signature
會員簽名

Date
日期

Mailing Address/ 郵寄地址：Grievances and Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569
Phone/ 電話：1-800-445-9090

EXPEDITED REVIEW
特急審查

The Plan makes every effort to process your appeal as quickly as possible. In some cases, you have a right to an expedited 72- hour appeal if your health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to 30 days. You may file an oral or written request for a 72-hour appeal. Call, write or fax the Plan. Ask for an "expedited review," a "72-hour review," or say, "I believe my health could be seriously harmed by waiting for a standard review."/ 本計畫竭盡全力儘快處理您的上訴。在某些情況下，如果等待標準上訴 (最多可能需要 30 天) 將嚴重傷害您的健康或機能，您有權要求 72 小時特急上訴。您可以口頭或書面要求 72 小時上訴。請致電、寫信或傳真到本計畫。要求「特急審查」、「72 小時審查」，或說「我認為我的健康可能因為等待標準審查而受到嚴重傷害。」

Call/ 致電：

1-800-445-9090 (5 a.m. - 8 p.m. Pacific/ 太平洋時間上午 5:00 至下午 8:00)
TTY 711

Or Write/ 或寫信：

Grievances and Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

Or Fax/ 或傳真：

(714) 364-6266

FOR ALL CALIFORNIA MEMBERS
給所有 CALIFORNIA 會員

If a complaint has been sent for immediate expedited review, the Plan will immediately inform you in writing of your right to notify the Department of Managed Health Care of the grievance. The Plan will provide you and the Department of Managed Health Care with a written statement of the disposition of pending status of the expedited review no later than three days from receipt of the complaint./ 如果是提出投訴要求立即進行特急審查，本計畫會立即以書面通知您有權通知醫療保健計畫管理局您的申訴。本計畫最遲會於接獲投訴起三天內，以書面方式告訴您和醫療保健計畫管理局，特急審查目前的處置狀態。

The following language is required by the Department of Managed Health Care:
以下文字由醫療保健計畫管理局規定註明：

"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 **1-800-445-9090** or **TTY 711** and use your health plan's grievance process before contacting the department. 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."/ 「加州醫療保健計畫管理局負責管理健康照護服務計畫。如果您想對您的健保計畫提出申訴，首先應致電您的健保計畫 **1-800-445-9090 或 TTY 711 (聽障專線)** 並使用您健保計畫的申訴流程，之後再與管理局聯絡。使用此申訴程序並不會妨礙您可能可利用的任何潛在法定權利或救濟措施。如果您的申訴案件涉及緊急情況，或是未獲健保計畫妥善處理，又或是超過 30 天仍未獲得解決時，您可致電管理局請求協助。您也可能符合獨立醫療審查 (IMR) 的資格。如果您符合 IMR 的資格，

則 IMR 流程將會針對健保計畫對提議的服務或治療是否為醫療所需、實驗性或研究性的治療是否屬於承保範圍，以及有關急診或緊急醫療服務給付爭議而做成的醫療決定，進行公正無私的審查。管理局也設有免付費電話 **(1-888-HMO-2219)**，並為聽語障人士提供聽障專線 **(1-877-688-9891)**。管理局網站 **http://www.hmohelp.ca.gov** 也提供線上的申訴表、IMR 申請表和說明。」