Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-443-0815** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-443-0815**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-443-0815** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-443-0815** (TTY: **711**)번으로 전화해 주십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-800-443-0815** (TTY (հեռատիպ)՝**711**):

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-443-0815**（TTY:**711**）まで、お電話にてご連絡ください。

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-443-0815** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-443-0815** (TTY: **711**)។

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-443-0815** (TTY: **711**).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-443-0815** (TTY: **711**) पर कॉल करें।

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-443-0815** (TTY: **711**).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: **711**) **1-800-443-0815** تماس بگیرید.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **5180-344-008-1-** (رقم هاتف الصم والبكم: **117-**).

Member Grievance Form

09574-212 (12-21) FOR SPANISH USE 0974-012, CHINESE-09574-112

KAISER PERMANENTE®

You may file your Grievance/Appeal by one of the following ways:

- By mail to Kaiser Foundation Health Plan:

  Member Case Resolution Center (For non-urgent/emergent standard grievances).
  P.O. Box 1809
  Pleasanton, CA 94566

  OR

  Expedited Review Unit and Part D Unit (For urgent/emergent pre-service grievances when the non-urgent time frame (a) could seriously jeopardize your life, health, or ability to regain maximum function, (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services that are subject of the grievance, or (c) a provider has told us that the matter is urgent).

  P.O. Box 1809
  Pleasanton, CA 94566
- To a Member Services representative at your local Member Services Department.
- Orally, to the Member Services Contact Center, 24 hours a day, seven days a week, excluding holidays.

English:	**1-800-464-4000**
Spanish:	**1-800-788-0616**
Chinese dialects:	**1-800-757-7585**
TTY:	**711**
- Online, through our Web site at **kp.org**

Notice of Nondiscrimination

Kaiser Foundation Health Plan (KFHP) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., seven days a week.

If you believe that KFHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

In California, Kaiser Permanente is an HMO plan and a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

KAISER PERMANENTE®

GRIEVANCE/APPEAL FORM – Medicare

California

Member/Patient Name		Medical Record Number	
Address Street		City	ZIP Code
Daytime Telephone Number	Alternate Telephone Number	Birth Date	
Name of Person Filing: (If different than above, a Statement of Authorized Representative form will be mailed to the member for completion):	Relationship	Daytime Telephone Number	
Department/Location and Medical Facility where issue occurred:		Date Issue Occurred	

Please describe the nature of the issue (attach additional sheets if needed):

Please explain how you tried to resolve this issue.

What would you consider a proper solution to this issue?

Signature	Date

For Program Representative Use Only

Name of Program Representative	Facility	Date Received

☐ Medicare Grievance ☐ Part D Drug Coverage Determination ☐ Part D Drug Redetermination ☐ Medicare Organization Determination ☐ Medicare Reconsideration ☐ Medi-Medi ☐ Fed-Med ☐ PERS-Medi

You will be advised of any additional procedural and appeal rights to which you are entitled as we move forward with your issue.

DO NOT FILE IN PATIENT CHART