Complaints, Grievance, and Appeals for California members

How to file a Grievance

Golden West has a formal process for reviewing member grievances and appeals. This process provides a uniform and equitable treatment of your grievance/appeal and a prompt response.

Golden West shall ensure that all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with visual or other communicative impairment. Such assistance shall include, but not be limited to, translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

Definition of a Grievance

A grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a member or the member's representative. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Members have up to 180 calendar days from the date of an incident or dispute, or from the date the member receives a denial letter, to submit a grievance or appeal to Golden West.

Standard Grievance/Appeal Review

Steps in the process

1. File your grievance or appeal with Golden West. You may also authorize someone to represent you. Authorizatior must be in writing. Call customer service for the authorization form. Your customer service number is on the back of your membership card.

You can file your grievance or appeal by:
   a. Calling customer service. Your customer service number is on the back of your membership card.
   b. Mail a letter or a completed grievance form which you can get on the website or by calling customer service or
   c. Submitting a grievance form online.

2. We will send you an acknowledgement letter within five (5) calendar days of receipt.

3. We will fully investigate your grievance/appeal, including all aspects of medical care involved. All medical records and/or responses that will assist with review of your case are requested. Clinical grievances/appeals are reviewed by staff medical personnel and physician specialists.. Non-medical grievances are reviewed by grievance specialists. We will provide a written response to you within 30 calendar days after we receive your grievance/appeal.

Expedited Review

The grievance system includes an expedited review process for urgent grievances and appeals. A grievance/appeal is expedited when a delay in decision-making may seriously jeopardize the life or health of a member or their ability to regain maximum function. This includes but is not limited to severe pain, potential loss of life, limb or major bodily function.

Steps in the process

1. File your request for an expedited grievance or appeal with Golden West using one of the methods listed in the standard grievance process. You may also authorize someone to represent you. Authorization must be in writing. Contact customer service for the authorization form. Your customer service number is on the back of your membership card. Calling customer service is the recommended method for requesting an expedited review.

2. A physician will review your request and make a determination within 72 hours. If your request does not qualify for an expedited review, your grievance/appeal will be reviewed in the standard 30-day grievance process. You will be notified by mail if you do not qualify for expedited review.

3. There is no requirement that members participate in the health plan's grievance/appeal process prior to contacting the DMHC for assistance regarding an urgent (expedited) appeal.