MOLINA HEALTHCARE
Your Extended Family.

2023 Summary of Health Insurance Grievance Procedures

You, your provider, or an authorized representative, may file an Administrative Grievance within 180 calendar days after receiving the initial determination notice from Molina Healthcare of New Mexico, Inc. (Molina Healthcare). A form you can use to file the grievance is included in this notification. You may file your grievance via phone, mail, electronic mail (e-mail), fax, or on the Molina Healthcare website below. Please submit your written grievance to:

Molina Healthcare of New Mexico
Grievance and Appeals Unit
PO Box 182273
Chattanooga, TN 37422
Fax #: (505) 342-0583

E-Mail: Marketplace.Grievances@MolinaHealthCare.Com
Website:
https://www.molinamarketplace.com/marketplace/nm/en-us/Members/Members%20Resources/gna

If you need assistance in preparing the grievance, you may contact Molina Healthcare at: **1 (888) 295-7651 Monday through Friday, 8:00 a.m. to 6:00 p.m. (Local Time).** If you are hearing impaired, you may contact Molina Healthcare through our dedicated TTY line toll free at **1 (800) 659-8331** or by dialing the **National Relay Service at 711.**

If you want your provider or other designated representative to file a grievance for you, you will need to give him/her your signed, written permission using the form attached.

Definitions

- **Administrative Grievance:** An oral or written complaint submitted by you, or someone on your behalf, regarding an administrative decision.
- **Administrative Decision:** A decision made by a health care insurer regarding any aspect of a health benefits plan other than an adverse determination, including, but not limited to:
  - Administrative practices of the health care insurer that affects the availability, delivery or quality of health care services;
  - Claims payment, handling or reimbursement for health care services, including but not limited to complaints concerning co-payments, co-insurance and deductibles; and
  - Terminations of coverage.
- **Day or Days:** Shall be interpreted as follows; unless otherwise specified:
  - One to five (1-5) days means only working days and excludes weekends and state holidays; and
  - Six (6) days or more means calendar, including weekends and holidays.

Administrative Grievance Process

Internal Review – Level I

- Once your request for an internal review has been received by Molina Healthcare, we will send you a written acknowledgement of your Administrative Grievance within three (3) working days after its receipt.
- The initial review shall:
  - Be conducted by a health care insurer representative authorized to take corrective action on the administrative grievance; and
  - Allow the grievant to present any information pertinent to your administrative grievance.
- Molina Healthcare will mail a written decision to you within thirty (30) calendar days of receipt of the Administrative Grievance.

Reconsideration of Internal Review – Level II

- Within twenty (20) calendar days of receiving the response letter from the initial internal review of your Administrative Grievance, you may request a committee hearing of your grievance.

Reconsideration of Internal Review – Reconsideration Committee

- If you are not satisfied with the outcome of the initial internal review of your Administrative Grievance, Molina Healthcare will appoint a reconsideration committee consisting of Molina Healthcare employees who have not participated in the initial internal review to review your Administrative Grievance.
- Upon receipt of your request for a reconsideration committee hearing, Molina Healthcare will schedule and hold a hearing within fifteen (15) calendar days after receiving your request for reconsideration. Molina Healthcare will not unreasonably deny your request for postponement of the reconsideration committee hearing.
- We will notify you in writing of the hearing date, time and place of the reconsideration committee hearing at least five (5) working days in advance.
- No fewer than three (3) working days prior to the hearing, Molina Healthcare will provide you with all the documents and information that the reconsideration committee will rely on in reviewing your Administrative Grievance.
- Your rights as the grievant during the internal review:
  - Attend the reconsideration committee hearing;
  - Present the grievant's case to the reconsideration committee;
  - Submit supporting material both before and at the reconsideration committee hearing;
  - Ask questions of any reconsideration committee members; and
  - Be assisted or represented by a person of your choice.
- We will mail a written decision to you within seven (7) calendar days after the reconsideration committee hearing.

External Review of Administrative Grievance by the Office of Superintendent of Insurance (the Superintendent)

- Within twenty (20) calendar days of receipt of the reconsideration committee's written notice of its decision, you may file a request for an external review via mail, e-mail, fax, or online. You may also file any other supporting documents or information you wish to submit to the Superintendent for review.
- The Superintendent may require you to exhaust the Molina Healthcare's internal Administrative Grievance

process before accepting an Administrative Grievance for external review. However, you may not be required to exhaust Molina Healthcare's process if:
  - We waive this requirement;
  - We fail to comply with the requirements of our internal review process.
- If you wish to supply supporting documents or other information after you have filed your request for external review by the Superintendent, the timeframe for completing the review will be extended up to ninety (90) calendar days from the receipt of your request form, or until you submit all supporting documents, whichever comes first.
- Upon receipt of a request for external review, the Superintendent will immediately send you an acknowledgment that the request has been received. The Superintendent will also send Molina Healthcare a copy of your request for external review.
- Upon receipt of the copy of the request for external review, Molina Healthcare will provide the Superintendent within five (5) working days all necessary documents and information considered in arriving at the Administrative Grievance decision.
- The Superintendent must issue a written decision on the Administrative Grievance within forty-five (45) calendar days of receipt of the complete request for external review.

A request for external review can be submitted to the Superintendent via mail, e-mail or fax. You may also complete the online request available at:

Office of Superintendent of Insurance
Attn: Managed Health Care Bureau
1120 Paseo de Peralta
PO Box 1689
Santa Fe, New Mexico 87504-1689

mhcb.grievance@osi.nm.gov
Phone: Local (505-827-4601) or Toll Free (855-427-5674)
Fax: (505-827-4253)

Link to complaint form: https://www.osi.state.nm.us/pages/misc/mhcb-complaint

Link to full version of health insurance grievance procedures:
www.osi.state.nm.us/pages/bureaus/mhcb/resources/grievance

Molina Healthcare of New Mexico
Grievance Form

If you want to file an Administrative Grievance, please fill out this form.

If you have questions or need help completing this form, please call **1 (888) 295-7651.**

Please Print. Date: ___________________

Member's ID #: ____

Member's LAST name: _________________________________

Member's FIRST name:_________________________ MI: ________

Current Address: ____

City:____State:_________________Zip:________________

Phone number: __________________________________

Doctor's Name: __________________________________

Specific Issues:

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Please mail all supporting documentation regarding your grievance to:

Molina Healthcare of New Mexico
Grievance and Appeals Unit
PO Box 182273
Chattanooga, TN 37422

Fax #: (505) 342-0583

E-Mail: Marketplace.Grievances@MolinaHealthCare.Com

Authorized Representative Permission Statement

If your healthcare provider or another individual is filing the grievance for you, you must give your written permission.

I,____(your name), give my permission for

____(designee) to file this Grievance Form.

____ ________________________________

Client's Signature Date