# MEMBER GRIEVANCE SUBMITTAL FORM

The health care you receive and your experience with Sonder Health Plans is important to us. If you have a complaint related to our Plan or any aspect of the care you have received, we want to know about it. You can use this form to tell us about your issue and to let us know how we can help.

Complaints should be filed with the Plan no later than 60 days from the date of the event/issue.

To submit a complaint to Sonder Health Plans, please complete this form and submit it to us, along with any supporting documents (such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your doctor). You can submit them by mail or fax at the below.

**Mail to:**
Sonder Health Plans
ATTN: Grievance & Appeals Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

**Fax to:**
(941) 866-2319

If you have any questions or need assistance with this form, please call the Grievance and Appeals Department directly at (888) 428-2110, Option 2; TTY 711, Monday-Friday from 8 a.m. - 5 p.m.

## Member Information

Name (first and last): _____

Member Date of Birth: _____ Member Sonder Plan ID: _____

Street Address: _____

City: _____ Zip: _____ Phone: _____

*If you are not the Member and are submitting this grievance on behalf of the Member, please submit a completed Appointment of Representative (AOR) Form, which can be located on our website, under the How to Appoint a Representative tab, at: https://sonderhealthplans.com/for-members/member-resources/find-a-document-or-form/. You can also request the AOR form from Member Services at (888) 428-4440. The AOR Form must be completed, signed by the Member, and dated within a year to be valid. If you are already legally authorized to represent the Member, please attach the documentation (such as power of attorney or health care proxy) for our review. Providers are not*

## Issue Type

Type(s) of Complaint (select as applicable):

- ☐ Issues with Care Received
- ☐ Referral/Authorization Delay
- ☐ Denial of an Authorization
- ☐ Denial of a Payment
- ☐ Telephone Hold Times
- ☐ Office Wait Times
- ☐ Appointment Availability
- ☐ Provider Network
- ☐ Transportation Issues
- ☐ Translation Accessibility
- ☐ Member Documents
- ☐ Other: _____

## Issue Information

Date(s) of Service/Event/Issue: _____

Please provide a detailed summary of what happened. Include any dates and times, as well as any names of individuals (such as our employees, physician(s) and/or their staff, pharmacies, and other vendors or suppliers) involved. You may add additional pages if you need more space to include all the event details:

## Additional Information (complete as applicable)

Is this related to a Medical Service or Device? ☐ Yes ☐ No

Is this related to a Medication? ☐ Yes ☐ No

Authorization or Claim number (if applicable): _____

Physician/Prescriber (if applicable): _____

## Supporting Documentation Attached

What attachments (if any) are you including with this completed form:

☐ Explanation of Benefits
☐ Letter from your doctor
☐ AOR Form
☐ Bill Received Medical Record(s)
☐
☐ Other: _____

## How long will Sonder Health Plans take to process your grievance?

Sonder Health Plans will process grievances as quickly as possible and based on the Members health status, but no later than 30 days from the receipt of the request, or within 24 hours for expedited grievances.

***Note:*** *Sonder Health Plans may take a 14-day extension if the Member requests the extension, or if the Plan needs additional information and feels the delay is in the best interest of the Member. If Sonder Health Plans takes an extension, we will notify the Member in writing of the extension and explain the reason for the delay.*

## Do you need an expedited grievance?

Select if applicable:

☐ Yes, because I believe that I need to receive a decision within 24 hours.

☐ Yes, because I have included a letter from my physician stating that he/she feels this issue needs to be expedited.

☐ Yes, because this grievance is related to a decision not to grant me an expedited decision on an authorization for a medical service or device.

☐ Yes, because this grievance is related to a decision not to grant me an expedited decision on an authorization for a medication or drug that I have not yet received.

☐ Yes, because this grievance is related to the Plan's notification that they are extending the timeframe to make a decision on a request for an authorization or appeal for medical services or a medical device.

## Submitter Information & Signature

Select Submitter Type:

☐ I am the **Member** related to this complaint
☐ I am the **Member's Representative**

Submitter Name (Print first and last): _____

Submitter Signature: _____ Date: _____

depends on contract renewal.

# IMPORTANT MEMBER INFORMATION

Discrimination is against the law. Sonder Health Plans, Inc. does not and shall not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Sonder Health Plans complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Sonder Health Plans, there are ways to get help. You may file a complaint, also known as a grievance, with us at:

Sonder Health Plans
ATTN: Grievance & Appeals Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

If you need help filing a grievance, call Sonder Member Services department at 1 (888) 428-4440, TTY 711. We are open 8 a.m. to 8 p.m. seven days a week from October 1st to March 31st, and 8 a.m. to 8 p.m. Monday-Friday from April 1st to September 30th. You may also leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Additionally, you have the right to file a civil rights complaint with the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.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 (TDD 1-800-537-7697). Complaint forms are also made available at https://www.hhs.gov/ocr/complaints/index.html.

Sonder Health Plans provides auxiliary aids and services, free of charge, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate, contact 1-888-428-4440 (TTY: 711) for assistance.

**Language assistance services are available to you, free of charge, call 1-888-428-4440 (TTY: 711) for assistance.**

**Español (Spanish):** Llame al número arriba para recibir servicios gratuitos de asistencia lingüística.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский(Russian):**Позвонитепономеру,указанномувыше,чтобыполучитьбесплатныеуслугиперевода.
**ગુજરાતી (Gujarati):** ઉપર આપેલા નંબર પર કૉલ કરો ભાષા સહાય સેવાઓનો લાભ મેળવવા માટે.
**ภาษาไทย(Thai):** โทรตด ตอทหมายเลขดานบนนเพอรบ บรการชวยเหลอดานภาษาโดยไมเสยคาใชจาย.
**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.
**العربية (Arabic):** لارجاء للاتصال لرقم للمبين في للحصول لع مات انية للمساعدة غتك