6.1 Complaints

A complaint is any oral or written communication of dissatisfaction given by a member, family/caregiver, friend, provider on behalf of the member made to Senior Health Partners about the care and treatment a member receives from our staff or providers of covered services. Senior Health Partners will try its best to deal with member concerns or issues as quickly as possible.

Senior Health Partners cannot change the way a member receives services or the way they were treated by Senior Health Partner's staff or providers after tthe member filed a complaint. Interpreter services are also available to members who would like to file a complaint or appeal.

If a member asks you how to file a complaint direct them to: **1-800-633-9717** or to:

Senior Health Partners
Appeals and Complaints Department
PO Box 5166
New York, NY, 10274-5166
or
Fax: 1-646-313-4618

The member will need to provide their name, address, telephone number and the details of the problem.

Members may file a complaint with us orally or in writing. The person who receives their complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send the member a letter telling them that we received their complaint and a description of our review process. We will review their complaint and give a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to the member's health, we will address the complaint within 48 hours after receipt of all necessary information.
2. For all other types of complaints, we will notify the member of our decision within 45 days of receipt of all necessary information, but the process must be completed no later than 60 days of the receipt of the complaint. The review period can be increased up to 14 days if we need more information and the delay is in the member's interest.

If the member is not satisfied with the decision we make concerning their complaint, they may request a second review of their issue by filing a complaint appeal. Complaint appeals must be in writing and must be filed within 60 business days of receipt of our initial decision about their complaint. Once we receive the appeal, we will send a written acknowledgement. All complaint appeals will be conducted by appropriate staff who were not involved in the initial decision.

For standard complaint appeals, we will make the decision within 30 business days after we receive all necessary information. If a delay in making our decision would significantly increase the risk to the member's health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

A report of all complaints is submitted to the Department of Health on a quarterly basis.