



**OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS
DISTRICT OF COLUMBIA GOVERNMENT
(HEALTH BENEFITS PLAN MEMBERS' BILL OF RIGHTS PROGRAM)
REPORTING FORM
(D.C. CODE 44-301.10, 2001 Edition)**

REPORTING PERIOD: _____ **NAIC#:** _____

Months Reported: _____
Company Name: _____
Mailing Address: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION ON THE PERSON RESPONSIBLE FOR PROVIDING THIS GRIEVANCE INFORMATION:

Staff Contact: _____
Staff Title: _____
Mailing Address: _____

Staff Phone: _____
Staff Fax: _____
Staff E-mail Address: _____

IMPORTANT

IF YOUR COMPANY HAS NO GRIEVANCES TO REPORT FOR THIS FILING PERIOD, AND/OR IS EXEMPT FROM FILING A REPORT WITH THE DISTRICT OF COLUMBIA GOVERNMENT – OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS, PLEASE RESPOND AS APPROPRIATE, ATTACH APPROPRIATE DOCUMENTS, DATE AND SIGN BELOW AND **RETURN ONLY THIS FIRST PAGE OF THE FORM AND DOCUMENTS TO THE ADDRESS BELOW:**

Our Company has **NO GRIEVANCES** to report for this filing period.

Our Company is exempt from filing a Report of Grievances. Documentation granting this exemption is attached.

AUTHORIZED SIGNATURE: _____ DATE: _____

TITLE: _____ PHONE: _____

RETURN TO:

Office of the Health Care Ombudsman and Bill of Rights
District of Columbia Government
899 North Capitol Street, N.E., 6th Floor
Washington, D.C. 20002
Phone: (202) 724-7491- Fax: (202) 535-1216
E-Mail: healthcareombudsman@dc.gov - Website: www.healthcareombudsman.dc.gov

REPORTING PERIOD: _____

NAIC#: _____

COMPANY NAME: _____

1. Please provide the aggregate number of grievances filed (and resolved) with your company during the period for which you are reporting.

TOTAL GRIEVANCES: _____

2. Please breakdown the aggregate number provided in your answer to Question 1 into the following categories:

	DESCRIPTION	TOTAL	UPHELD	OVERTURNED	PARTIAL OVERTURNED
A	In-patient Hospital Services				
B	Emergency Room Services				
C	Mental Health Services				
D	Physician Services				
E	Laboratory, Radiology Services				
F	Pharmacy Services				
G	PT, OT, ST Services (including In-patient rehabilitation service)*				
H	Skilled Nursing, Sub-Acute Facility, Nursing Home Services				
I	Durable Medical Equipment				
J	Podiatry Services				
K	Dental Services				
L	Optometry Services				
M	Chiropractic Services				
N	Home Health Services				
O	Other				
	TOTAL:				

***IN-PATIENT ACUTE REHABILITATION SERVICES ARE REPORTED WITH IN-PATIENT ACUTE HOSPITAL SERVICES SINCE ACUTE REHABILITATION AND ACUTE IN-PATIENT ADMISSIONS ARE PART OF THE SAME REPORTABLE BENEFIT STRUCTURE.**

REPORTING PERIOD: _____
 COMPANY NAME: _____

NAIC# _____

For each category identified in Question 2, please list five most common procedures/services/items that were at issue in the grievance and the final disposition as requested below:

GRIEVANCE BY SPECIFIC ICD-9 CODE AND DESCRIPTION

	ICD-9 CODE AND DESCRIPTION	TOTAL	UPHELD	OVERTURNED	PARTIAL OVERTURNED
A					
A					
A					
A					
B					
B					
B					
B					
C					
C					
C					
C					
D					
D					
D					
D					
E					
E					
E					
E					
F					
F					
F					
F					
G					
H					
I					
J					
K					
L					

REPORTING PERIOD: _____
COMPANY NAME: _____

NAIC# _____

3. Please provide the aggregate number of grievances filed and resolved by your company during this reporting period that involved a Hospital Length of Stay/Denial of Hospital Days:

Aggregate number of grievances involving a Hospital Length of Stay/Denial of Hospital days: _____

Please breakdown the aggregate number of grievances in your answer to Question 3 into the following categories:

GRIEVANCES INVOLVING HOSPITAL LENGTH OF STAY/DENIAL OF DAYS

ICD-9 CODE AND DESCRIPTION	TOTAL	UPHELD	OVERTURNED	PARTIAL OVERTURNED
TOTAL:				

REPORTING PERIOD: _____
COMPANY NAME: _____

NAIC# _____

4. Please provide the aggregate number of grievances filed and resolved by your company during this reporting period that were considered **EMERGENCY/EXPEDITED CASES**:

Aggregate number of grievances that were considered
Emergency/Expedited Cases: _____

Please breakdown the aggregate number of grievances in your answer to Question 4 into the following categories:

GRIEVANCES INVOLVING EMERGENCY/EXPEDITED CASES

ICD-9 CODE AND DESCRIPTION	TOTAL	UPHELD	OVERTURNED	PARTIAL OVERTURNED
TOTAL:				

REPORTING PERIOD: _____
COMPANY NAME: _____

NAIC# _____

5. **Statistical Time for Resolution:** For both grievances considered to be emergency cases and those that were not emergency cases, please provide the average time within which your company made a grievance decision. For non-emergency cases, please express time in calendar days only.

Resolution time for EMERGENCY CASES: _____ Hours

Resolution time for Mental Health Cases: _____ Hours
(EMERGENCY CASES)

Resolution time for NON-EMERGENCY CASES: _____ Calendar Days

Resolution time for Mental Health Cases: _____ Calendar Days
(NON-EMERGENCY CASES)

6. Please describe any changes that have been made to your company's internal grievance process during the preceding year. (Attach copies)