



WHAT IS A GRIEVANCE?

A grievance is an expression of dissatisfaction.

If you are not happy with the way your services are being provided or how you are being treated, we would like to know. DWIHN promotes member access to high quality and person-centered behavioral health care services. Your voice is important in helping DWIHN in identifying opportunities for improvements in quality and delivery of behavioral health care services for citizens in Detroit-Wayne County.

WHO CAN FILE A GRIEVANCE?

A grievance can be filed by anyone receiving services or a representative on your behalf. Grievances can be filed in writing over the phone or in person at any time.

TIMEFRAMES

Your grievance will be acknowledged in writing within 5 calendar days of receipt. The grievance process may take up to 90 calendar days to resolve. However, your grievance will be resolved as quickly as your health condition requires. Once your grievance has been resolved, you will be notified in writing.

For assistance in filing a grievance or to ask any questions about grievances, you may contact Customer Service at:

Detroit Wayne Integrated Health Network
707 W. Milwaukee St.
Detroit, Michigan 48202
1-888-490-9698



WHAT IS AN APPEAL?

An appeal is a request for a review of an adverse benefit determination. If you have services that you would like to receive or are currently receiving that have been denied, reduced, suspended or terminated for any reason, **YOU HAVE THE RIGHT** to appeal that decision. There are a few different ways that you can request an appeal. An appeal can be requested in writing, over the phone or in person.

WHO CAN REQUEST AN APPEAL?

An appeal can be requested by the enrollee, the enrollee's legal guardian or authorized representative.

TIMEFRAMES

You can request an appeal within 30 to 60 days of receiving the adverse benefit determination notice or denial of medical coverage letter depending upon your insurance. Your appeal will be acknowledged in writing within 5 calendar days of receipt. The local appeal process can take up to 30 days. After your appeal has been researched and a decision made, you will receive a Notice or Notice of Approval letter. If you disagree with the outcome of your appeal, you can request a State Fair Hearing (Medicaid Services only), Alternate Dispute Resolution (uninsured/underinsured members only) or a Maximus review (Medicare Services).

For additional information, please contact Customer Service at:

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