COMPLAINT/GRIEVANCE PROCEDURES

All complaints whether verbal or written must be received no later than the 90th day after the date of the event or occurrence that is the basis for the complaint.

Upon receipt of the complaint, USA Worker's Injury Network's (USA WIN's) Executive Director will review the information and confirm that the complaint was received within 90 days of the event. If the complaint was received outside of the 90 day period, USA WIN's Executive Director may send a letter acknowledging receipt of the complaint and decline to act upon the complaint as it was received outside of the allotted time for filing. If the complaint was received within the 90 day period USA WIN's Executive Director will send a letter to the complainant within 7 calendar days acknowledging receipt, the date and description of the complaint and a copy of the Complaint/Grievance Form (**Attachment A**) for the appealing party to complete if the complaint was received verbally. USA WIN's Executive Director is responsible for confirming a final determination/resolution is conveyed to the complainant within 30 calendar days. The final determination/resolution will address the network's resolution of the complaint, the specific reason(s) for the resolution, and the specialization of any healthcare provider consulted.

Complainant may file a complaint with the Texas Department of Insurance (TDI) if for any reason they are dissatisfied with how USA WIN handled the complaint. This includes any person who has attempted to resolve a complaint through USA WIN's complaint process or attempted to resolve a dispute regarding whether the employee lives within USA WIN's service area through the insurance carrier.

Complaint forms can be found at www.tdi.state.tx.us *or by writing:*

Texas Department of Insurance
HMO Division, Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104

Complainant is entitled to a copy of the record pertaining to the complaint as well as any proceeding relating to that complaint. Complainant can request a copy by writing to:

USA Worker's Injury Network
Executive Director PNA
1250 S. Capital of Texas Highway, Bldg 3-500
Austin, TX 78746

USA Worker's Injury Network will never retaliate against:

a) An employee or employer, who files a complaint against USA WIN or appeals a decision of USA WIN, or
b) A provider who, on behalf of the employee, files a complaint against USA WIN or appeals a decision of USA WIN.

ATTACHMENT A

FOR INTERNAL USE ONLY	
DATE RECEIVED	
CONCERN #	

COMPLAINT/GRIEVANCE FORM

Complaint Initiated by: Provider ☐ Employee ☐ Employer ☐ Carrier ☐

Complaint Involves: Service ☐ Medical Care ☐ Other ☐

INITIATOR OF COMPLAINT

Name (Last, First):		
Address:		
City:	State:	Zip:
Telephone #: ( )		

Employee Name:			Employer Name:		
Address:			Address:		
City:	ST:	Zip:	City:	ST:	Zip:
Telephone#: ( )			Telephone#: ( )		
SSN:					

Group Name:			Insurer:		
Provider Name:			Contact:		
Address:			Address:		
City:	ST:	Zip:	City:	ST:	Zip:
Telephone#: ( )			Telephone#: ( )		

Date of Injury:	Date of Disputed Action:

*** Note: USA Worker's Injury Network cannot thoroughly investigate this complaint/grievance without written consent to obtain copies of your medical records or other related documents. Records are kept confidential and used solely for the purpose of grievance resolution.*

☐ Yes, I hereby authorize USA Managed Care Organization/USA Worker's Injury Network permission to obtain and review all medical and/or other related records. You may disclose my name and nature of this concern in order to obtain additional information. I agree to a Photostat and/or facsimile of this release being accepted, if necessary.

☐ No, I do not authorize disclosure of my name or nature of this concern in order to obtain additional information.

Complainant Signature:_____ Date:_____

COMPLAINT/GRIEVANCE FORM (CONTINUED)

Please provide a narrative of the nature of your grievance. Include all pertinent information including; contact names, dates of service, correspondence and conversations. Please attach copies of all documents related to the grievance, if applicable. You will receive written confirmation from USA upon our receipt of the Grievance Form. Your Grievance will be thoroughly researched and all information will be submitted to USA's Medical Review Committee at the next regularly scheduled meeting for consideration and action. Thank you for taking time to complete and return this form.

Please submit to:

USA MANAGED CARE ORGANIZATION
USA WORKER'S INJURY NETWORK
Attn: Executive Director PNA
1250 S. Capital of Texas Highway, Bldg 3-500
Austin, TX 78746

Toll Free 800.872.0820
Fax: 512.328.6785
E-Mail: medicalreviewcommittee@usamco.com

*****All Complaints must be filed within 90 days from the date of Disputed Action *****