HOW TO FILE A GRIEVANCE OR AN APPEAL

Member satisfaction is very important to CarePlus. If you have a problem or concern, usually calling our Member Services Department is the first step. Please call our Member Services Department at 1-800-794-5907 and they will let you know if there is anything else you need to do. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. TTY users should call 711.

If you do not wish to call (or you called and are not satisfied), you can put your grievance in writing and send it to us. You may download a Grievance or Appeal Form from our website at https://www.careplushealthplans.com/members/.

You or your authorized representative may submit your written grievance and/or appeal request to the CarePlus Grievance & Appeals Department at the following address or fax number:

CarePlus Health Plans, Inc.
11430 NW 20th Street, Suite 300
Miami, FL 33172
Attn: Grievance & Appeals Department
Fax number: 1-800-956-4288

If you want, you can name another person to act for you as your authorized representative to file a grievance or an appeal. Instructions on how to appoint a representative can be found on page 8 of this document. You can also call our Member Services Department at the phone number listed above to request an Appointment of Representative Form or to ask questions about how to appoint a representative.

HOW TO FILE A GRIEVANCE

A **grievance** is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of CarePlus, or its providers. A grievance does not involve coverage or payment disputes.

Some examples of why you or your authorized representative might file a grievance include the following:

- Are you unhappy with the quality of care you have received (including care in the hospital)?
- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- Has someone been rude or disrespectful to you?
- Are you unhappy with how a representative from our Member Services Department has treated you?
- Do you feel you are being encouraged to leave the plan?
- Are you having trouble getting an appointment or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services department or other staff at the plan? (Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.)

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- Do you believe we have not given you a notice that we are required to give?

You may request an expedited (fast) grievance if your grievance concerns one of the following circumstances:

- You disagree with our decision to extend the timeframe to make an initial organization determination or appeal (reconsideration).
- We deny your request for an expedited (fast) organization determination/coverage determination.
- We deny your request for an expedited (fast) appeal.

If your grievance meets any of the above criteria for a fast grievance, we will respond within 24 hours of receipt of request.

For all other grievances, CarePlus will notify you or your authorized representative of our decision as quickly as your case requires based on your health status, but not later than 30 calendar days after receiving your grievance. In some cases, we may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest. If we decide to take extra days to make the decision, we will tell you in writing.

You or your authorized representative may file a grievance with CarePlus orally or in writing. You can file an oral grievance by calling our Member Services Department at 1-800-794-5907. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. TTY users should call 711.

You can also send us a written grievance by mailing or faxing your written complaint to:

CarePlus Health Plans, Inc.
11430 NW 20th Street, Suite 300
Miami, FL 33172
Attn: Grievance & Appeals Department
Fax number: 1-800-956-4288

When filing a written grievance, please provide the following information:
Your name, address, telephone number, member identification number, your signature (optional), date, details about your issue and any previous contact with us, and the action you are requesting from us.

The Grievance or Appeal Form is available for download from our website at https://www.careplushealthplans.com/members/. You may contact also our Member Services Department to request a Grievance or Appeal Form.

HOW TO FILE AN APPEAL

What if I am denied a service or claim? *(If you were denied a Part D prescription drug, go to page 6).*

Medical care: includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. We will show below how the rules for Part B prescription drugs are different from the rules for medical items and services.

A **reconsideration** is a formal way of asking CarePlus to review a denied medical care coverage decision (organization determination). If CarePlus has made an organization determination and you are not satisfied with this decision, you, your authorized representative, or your doctor can appeal the decision. In this appeal, we review the organization determination we made. Your appeal is handled by a different reviewer than those who made the original unfavorable decision. When we have completed the review, we will give you our decision.

There are five levels to the appeals process:

Level 1: Reconsideration by CarePlus
Level 2: Review by the Independent Review Entity
Level 3: Hearing by an Administrative Law Judge or attorney adjudicator
Level 4: Review by the Medicare Appeals Council
Level 5: Review by a Federal District Court

The first step is to appeal to CarePlus (Level 1 appeal). Appeal requests must be filed with CarePlus within **60 calendar days** from the date of the notice of the organization determination. If the appeal request is submitted after the 60-day filing deadline, you must include a statement in writing explaining the reason why you didn't submit the appeal on time.

You may file a request for an **expedited (fast) appeal** orally or in writing. You can only request a fast appeal for care you have not yet received and if you believe that using the standard deadlines could cause serious harm to your health or hurt your ability to function. You cannot get a fast appeal if your request is about payment for medical care you have already received. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal. If you ask for a fast appeal on your own, without your doctor's support, we will decide whether your health requires that we give you a fast appeal.

You can file a request for an oral fast appeal or obtain further assistance by calling our Member Services Department at 1-800-794-5907. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. TTY users should call 711.

Standard appeal requests must be made in writing.

You can send us a standard or fast written appeal request by mail or fax to:

CarePlus Health Plans, Inc.
11430 NW 20th Street, Suite 300
Miami, FL 33172
Attn: Grievance & Appeals Department
Fax number: 1-800-956-4288

The Grievance or Appeal Form is available for download from our website at https://www.careplushealthplans.com/members/. You may also contact our Member Services Department to request a Grievance or Appeal Form.

When filing a written appeal, please provide the following information:

Your name, address, telephone number, member identification number, your signature (optional), date, provider name, date(s) of service (if applicable), and details about the issue you would like us to review for appeal. Please attach copies of any supporting information or documents that we should review, such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your provider.

Once we receive your request, we will make a decision and provide notice of our determination as quickly as your health requires, but not later than the following timeframes:

- **72 hours** for fast appeals
- **7 calendar days** for standard Medicare Part B prescription drug requests
- **30 calendar days** for standard requests if your appeal is about medical coverage for services you have not yet received (pre-service appeals)
- **60 calendar days** for appeals about coverage you have already received (claim appeals)

In some cases, we may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest. If we decide to take extra days to make the decision, we will tell you in writing.

If we deny all or part of your Level 1 appeal, your case will be automatically sent to the Independent Review Entity for a Level 2 appeal. At each appeal level, if the reviewing entity denies your appeal, their decision notice will contain the information needed to file an appeal request to the next level.

After review by CarePlus, all subsequent levels of appeal will be reviewed by a separate entity. This will help ensure a fair and impartial decision.

Medicaid Fair Hearing

For full dual eligible Medicare and Medicaid members ***only***, there is a State Fair Hearing process available for certain benefits. This is an additional level of appeal through Medicaid.

The following services may be covered by us based on our contract with the State Medicaid Office. Coverage of the benefits described below depends upon your level of Medicaid eligibility. These benefits may not be available to all enrollees.

- Adult Dental Services
- Adult Hearing Services
- Adult Vision Services
- AIDS Related Durable Medical Equipment and Supplies
- AIDS Related Massage Therapy

- Assistive Care Services
- Chiropractic Services
- Medicaid-covered drugs[1]
- Mental Health Targeted Case Management
- Nursing Facility Transitional Days
- Over-the-counter Products
- Podiatric Services
- Transportation

Step 1: You must follow the Medicare appeal process explained on pages 3-4 above.

Step 2: If you have no further Medicare appeal levels available to you, we will send you a letter with instructions on how to request a State Fair Hearing if:

- Your appeal was for a Medicaid benefit listed above, and
- We denied the benefit because we said it was not medically necessary.

You can choose whether to accept the decision of the last Medicare appeal level or request a State Fair Hearing. If you decide to go on, these instructions will tell you how to request a State Fair Hearing from the Agency for Healthcare Administration (AHCA) Medicaid Hearing Unit and what deadlines you must follow.

Step 3: To request a State Fair Hearing, you or your representative designated in writing must contact the Agency for Healthcare Administration (AHCA) Medicaid Hearing Unit and ask for a review of your case.

What to do:

- Follow the instructions listed in the letter from Step 2 to request a State Fair Hearing.
- If you are asking for a State Fair Hearing, make your request in writing within 120 calendar days from the date listed on the last appeal level's decision letter.

Step 4: The State Fair Hearing Officer does a review of your appeal and gives you an answer.

- The State Fair Hearing Officer will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

If you have additional questions about the State Fair Hearing process please contact AHCA at 1-877-254-1055 (Toll Free) or email your questions to MedicaidHearingUnit@ahca.myflorida.com. You can also contact our Member Services Department at 1-800-794-5907. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. TTY users should call 711.

[1] This is a 2020 plan year benefit.

What if I am denied a Part D prescription drug?

A **redetermination** (Part D) appeal is a formal way of asking CarePlus to review a denied coverage decision (coverage determination). If CarePlus has made a coverage determination and you are not satisfied with this decision, you, your authorized representative, or prescriber can appeal the decision. In this appeal, we review the coverage determination we made. Your appeal is handled by a different reviewer than those who made the original unfavorable decision. When we have completed the review, we will give you our decision.

There are five levels to the appeals process:

Level 1: Redetermination by CarePlus
Level 2: Reconsideration by the Independent Review Entity
Level 3: Hearing by an Administrative Law Judge or attorney adjudicator
Level 4: Review by the Medicare Appeals Council
Level 5: Review by a Federal District Court

The first step is to appeal to CarePlus (Level 1 appeal). Appeal requests must be filed with CarePlus within **60 calendar days** from the date of the notice of the coverage determination. If the appeal request is submitted after the 60-day filing deadline, you must include a statement in writing explaining the reason why you didn't submit the appeal on time.

You may file a request for an **expedited (fast) appeal** orally or in writing. You can only request a fast appeal for a drug you have not yet received and if using the standard deadlines could cause serious harm to your health or hurt your ability to function. You cannot get a fast appeal if you are asking us to pay you back for a drug you have already bought. If your prescriber tells us that your health requires a fast appeal, we will give you a fast appeal. If you ask for a fast appeal on your own, without your prescriber's support, we will decide whether your health requires that we give you a fast appeal.

You can file a request for an oral fast appeal or obtain further assistance by calling our Member Services Department at 1-800-794-5907. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. TTY users should call 711.

Standard appeal requests must be made in writing.

You can send us a standard or fast written appeal by mail or fax to:

CarePlus Health Plans, Inc.
11430 NW 20th Street, Suite 300
Miami, FL 33172
Attn: Grievance & Appeals Department
Fax number: 1-800-956-4288

The Medicare Part D Redetermination Request Form is available for download on our website at https://www.careplushealthplans.com/members/drug-coverage-determination. You may also contact our Member Services Department to request a redetermination request form.

When filing a written redetermination (Part D) appeal, please provide the following information:

You should include your name, address, telephone number, member number, the prescription drug you are requesting, prescriber's information, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health. Please attach copies of any supporting information or documents that we should review, such as medical records, medical bills, or a letter from your provider.

Once we receive your request, we will make a decision and provide notice of our determination as quickly as your health requires, but not later than the following timeframes:

- **72 hours** for expedited requests
- **7 calendar days** for standard requests
- **14 calendar days** for requests for payment

If we deny all or part of your Level 1 appeal, you can choose whether to accept the decision or continue appealing to the next level. In our decision notice, we will tell you how you can appeal to the Independent Review Entity. At each appeal level, if the reviewing entity denies your appeal, their decision notice will contain the information needed to file an appeal request to the next level.

After review by CarePlus, all subsequent levels of appeal will be reviewed by a separate entity. This will help ensure a fair and impartial decision.

Instructions on how to Appoint a Representative

If you want, you can name another person to act for you as your authorized representative to file a grievance, a coverage determination, an organization determination, or an appeal. The below instructions explain how you can appoint a representative.

You may appoint any individual (such as a relative, friend, advocate, an attorney, physician or other prescriber, or an employee of a pharmacy, charity, or other secondary payer) to act as your representative.

- To appoint a representative, you can fill out an Appointment of Representative (AOR) Form (CMS-1696). This form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- Alternatively, instead of completing the AOR Form, you may send us a written notice including the following items:
  - The name, address, and telephone number of the member;
  - The member's Medicare Beneficiary Identifier (MBI), the member's Medicare ID Number (HICN), or member's CarePlus plan ID number;
  - The name, address, and telephone number of the individual being appointed;
  - The appointed representative's professional status or relationship to the member;
  - A written explanation of the purpose and scope of the representation;
  - A statement that the member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
  - Signed and dated by the member making the appointment
  - A statement from the individual being appointed indicating that they accept the appointment; and
  - Signed and dated by the individual being appointed as representative.

- Your authorized representative has all the same rights and responsibilities as you in filing a grievance, obtaining a coverage decision (organization determination/coverage determination), or in dealing with any levels of the appeals process.

- The appointment is considered valid for one year from the date that the AOR Form is signed by both you and your representative, unless revoked. However, if you would like the same individual to continue serving as a representative after one year, you must reappoint that person by submitting a new representative form.

- There may be someone who is already legally authorized to act as your representative under state law (for example: court appointed guardian, Durable Power of Attorney, health care proxy, etc.). If this is the case, you must give us a copy of the legal documentation

appointing that person as your representative for our review.

For *medical care*, your doctor can request an organization determination or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

For *Part D prescription drugs*, your doctor or other prescriber can request a coverage determination, Level 1, or Level 2 appeal on your behalf. To request an appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

How to submit representative documentation

Please send the completed AOR Form, written notice, or other legal documentation to CarePlus by mail or by fax to:

CarePlus Health Plans
Attn: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172
Fax number: 1-800-956-4288

If you need a copy of an AOR Form or have any questions about this process, please contact our Member Services Department at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. A copy of the AOR Form can also be found on the next page.

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

IMPORTANT!

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
  CarePlus Health Plans, Inc. Attention: Member Services Department.
  11430 NW 20th Street, Suite 300. Miami, FL 33172.
  If you need help filing a grievance, call **1-800-794-5907 (TTY: 711)**. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.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, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711)

CarePlus provides free auxiliary aids and services, 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.

Language assistance services, free of charge, are available to you. 1-800-794-5907 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
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): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
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.
ગુજરાતી (Gujarati): નઃશૂલ્ક ભાષા સહાય સેવાઓ પ્રરાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કૉલ કરો.
ภาษาไทย (Thai): โทรไปยังหมายเลขที่ระบุข้างต้นเพื่อรับบริการช่วยเหลือด้านภาษาฟรี.
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'dęę niká'adoowoł.
العربية (Arabic):

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك