

Grievance Form for UnitedHealthcare Benefit Plan of CA

Attention: Community Plan, Medicare & Retirement, UHC West, Medicare Advantage members – do not complete this form.

You have the right to file a formal grievance about any of your medical care or services. If you want to file, please use this form. *You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department.* There is a process you need to follow to file a grievance. UnitedHealthcare, by law, must give you an answer within 30 days. If you have any questions, or prefer to file this grievance orally, please feel free to call UnitedHealthcare Customer Service at **1-800-260-2773 or 711 (TTY)**, Monday through Friday, 7 a.m. to 9 p.m. If you think that waiting for an answer from UnitedHealthcare will hurt your health, call and ask for an “Expedited Review.”

Current Personal Information (please print or type)				
Enrollment or Member ID #		Employer or Group Name		
Last Name	First Name		MI	Date of Birth
Address		Apt #	City	State ZIP
Home Telephone ()		Work Telephone ()		Extension
If someone other than the member is filing this grievance, please provide the following information:				
Name		Daytime Telephone ()		
Relationship to Member				
Address		Apt #	City	State ZIP

Due to privacy laws, you will be required to submit authorization of representation indicating you can file a complaint on behalf of the member.

Describe Your Grievance

Please describe your complaint. Be sure to include specific dates, times, people’s and providers’ names, places, etc. that were involved. Please send copies of anything that may help us understand your grievance to the address listed below or fax the documents to **1-801-938-2100 standard or if expedited 1-801-994-1083 for medical and 801-994-1345 pharmacy standard or 801-994-1058 pharmacy expedited.**

If you attach other pages, please check this box.

Notice to the member or your representative

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-260-2773 or 711(TTY)** and use your health plan's grievance process before calling the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of the medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD (1-877-688-9891)** for the hearing- and speech-impaired. The department's internet web site **<http://www.dmhc.ca.gov>** has complaint forms, IMR application forms and instructions online.

If you are a Federal Employee, you have grievance rights through the Office of Personnel Management (OPM) instead of the DMHC. Please reference your Federal Employees Health Benefits (FEHB) Program brochure, which states that you may ask OPM to review the denial after you ask UnitedHealthcare to reconsider the initial denial or refusal. OPM will determine if UnitedHealthcare correctly applied the terms of our contract when we denied your claim or request for service. Send your request for review to: Office of Personnel Management, Office of Insurance Programs Contracts Division 3, 1900 E Street NW, Washington, DC 20415-3630.

Signature

Your Signature

Date

Signature of Representative

Date

Please sign and mail or fax to:

ATTN: Appeals and Grievances
Department P.O. Box 30573
Salt Lake City, UT 84130-0573
FAX:

Medical 1-801-938-2100 standard
1-801-994-1083 expedited
Pharmacy 1-801-994-1345 standard
1-801-994-1058 expedited