

## **Instructions to help you complete the Member Grievance Form**

If you are a UnitedHealthcare Dual Complete member, please do not use this form.

### **GRIEVANCE RIGHTS**

What to do if you have a complaint

A grievance is a formal complaint. You can send a grievance when you are not happy with your health plan or the care you received.

If you send us a grievance in writing, we will send you a letter to say we received it. We will look into your complaint and try to fix the problem within 30 days. After that, we will send you another letter to explain what we did.

### **How to complete this form**

Fill out as much of the form as you can. You can type your information on the form and print it, or print a blank copy and fill it out by hand.

### **How to request a grievance**

Please mail this form and any other paperwork to:

UnitedHealthcare Community Plan  
Attn: Member Grievances  
P.O. Box 31364  
Salt Lake City, UT 84131-0364

### **What happens next**

We will send you a letter to let you know we received your grievance. We will look at your complaint and any papers you sent.

### **Choose an authorized representative**

You can pick someone to help you with your grievance. If you want someone to act for you, you must fill out and sign the Designation of Authorized Representative form.

Please send that form with your grievance request.

## Member Grievance Form – UHCCP NJ

To start this process fill this form out. Fill out as much information as you can. Sign and date the form and send it to us. Please attach copies of all information you would like us to use in our review.

<b>Member Information:</b> You can find this on your UHCCP NJ ID card			
First Name		Last Name	
Address			Apt #
City		State	Zip Code
Member ID#	Best phone number to reach you		
Your email address			

<b>Reason for your grievance</b> (formal complaint)? Check the issue that applies to you.	
<input type="checkbox"/>	Difficulty making an appointment.
<input type="checkbox"/>	Dissatisfaction with the way a provider or their staff treated me.
<input type="checkbox"/>	A provider refused to see me because of claims payment issues with the plan.
If you chose one of the above, please specify:	
Provider Name	
Date of Grievance	
<input type="checkbox"/>	Difficulty getting services authorized.
<input type="checkbox"/>	I was billed for covered services.
<input type="checkbox"/>	Dissatisfaction with the way health plan staff treated me.

