MINNESOTA - Applicable to fully insured members covered by an employer or individual plan on UnitedHealthcare of Illinois, Inc.

Complaint and Appeal Form for Managed Care Members

Attention Medicare Advantage members – do not complete this form.

You have the right to file a formal complaint or appeal about any of your medical care or services. If you want to file a complaint or appeal, please use this form. Please note: 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.

If you have any questions, or prefer to file this complaint or appeal 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 complaint, 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 or appeal on behalf of the member.

Describe your Complaint

Please describe your complaint or appeal. Be sure to include specific dates, times, names of people and providers, places, etc., that were involved. Please send copies of anything that may help us understand your complaint or appeal.

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If you attach other pages, check this box ☐

Sign below and Mail or Fax to:

Mail:
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)

Signature of Member or Representative (if applicable)	
Your Signature	Date
Signature of Representative (if applicable)	Date

Notice to the Member or Representative

You have the right to file a complaint or appeal with the Minnesota Department of Health at any time during the complaint and appeal process. If you are not satisfied with this decision, you or your authorized representative may contact the Minnesota Department of Health to request its review of this decision:

Minnesota Department of Health
Attn: Managed Care Section
P.O. Box 64882
St. Paul, MN 55164-0882
1-651-201-5100
1-800-657-3916