CALIFORNIA

UnitedHealthcare®

Grievance Form for UnitedHealthcare Benefits Plan of CA

Attention 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. You may use this form to submit a grievance for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals and Grievances Department. UnitedHealthcare will acknowledge receipt within 5 calendar days and provide an answer within 30 calendar days for a standard review. If your problem is urgent, UnitedHealthcare must give you a decision within 3 calendar days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly. You may also file a grievance using the online grievance form at benefits.surest.com or by mailing this form to the address below. If you have any questions, or prefer to file this grievance orally, please feel free to call UnitedHealthcare Customer Service at 1-866-683-6440 or TTY 711, Monday through Friday, 7 a.m. to 8 p.m. PST.

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 **1-866-683-6440** or TTY **711** 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 TDD line **(1-877-688-9891)** for the hearing- and speech-impaired. The department's internet website **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 31270 Salt Lake City, UT 84131

FAX:

Medical 1-801-938-2100 standard
1-801-994-1083 expedited

Pharmacy 1-801-994-1345 standard
1-801-994-1058 expedited