

# UnitedHealthcare Benefits Plan of CA 申訴表/ Grievance Form for UnitedHealthcare Benefits Plan of CA

Medicare Advantage 會員請注意 – 請勿填寫此表格。 / Attention Medicare Advantage members – do not complete this form.

您有權可針對您的任何醫療護理或服務提起正式申訴。您可以在任何引起您不滿的事件或行為發生後的 180 個日曆日內，使用此表格透過我們的上訴和申訴部門提交申訴。如果不提供跨性別包容的護理，您可以提出申訴。聯合健康保險 (UnitedHealthcare) 將於 5 個日曆日內確認收到，如果是標準審查，會在 30 個日曆日內作出回覆。如果您的問題緊急，聯合健康保險 (UnitedHealthcare) 必須在 3 個日曆日內把決定告訴您。如果您的健康受到嚴重威脅，必須迅速解決，那麼您的問題就是緊急的。您也可以網站 [benefits.surest.com](https://benefits.surest.com) 使用網上申訴表提起申訴，或將此表格寄到以下地址。如果您有任何疑問，或希望口頭提起這件申訴，您都可以致電聯合健康保險 (UnitedHealthcare) 客戶服務部，電話 1-866-683-6440，聽力語言殘障服務專線 (TTY) 711，週一至週五，太平洋標準時間 (PST) 上午 7 時至晚上 8 時。 / 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 within 180 calendar days following any incident or action that is the subject of your dissatisfaction through our Appeals and Grievances Department. You may submit a grievance for failure to provide trans-inclusive care. 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 by mail, fax or by submitting using the online grievance form at [benefits.surest.com](https://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.

☐ 如果這是緊急要求，請勾選此方框/ If this is an urgent request, please check this box

參加註冊或會員號碼/ Enrollment or Member ID #		僱主或團體名稱/ Employer or Group Name		
姓氏/ Last Name	名字/ First Name		中間名首字母 (MI)	出生日期/ Date of Birth
地址/ Address	公寓號碼/ Apt #	城市/ City	州/ State	郵遞區號/ ZIP
住家電話/ Home Telephone ( )		工作地點電話/ Work Telephone ( )		分機/ Extension
如果是會員以外的人提起此申訴，請提供以下資訊：/ If someone other than the member is filing this grievance, please provide the following information:				
姓名/ Name		日間電話/ Daytime Telephone ( )		
與會員的關係/ Relationship to Member				
地址/ Address	公寓號碼/ Apt #	城市/ City	州/ State	郵遞區號/ ZIP

根據隱私權法律規定，您必須提交代表授權，證明您可以代表會員提出投訴。 / Due to privacy laws, you will be required to submit authorization of representation indicating you can file a complaint on behalf of the member.

## 說明您的申訴/ DESCRIBE YOUR GRIEVANCE

請說明您的投訴。務必要包括與事件相關的特定日期、時間、人名及醫療護理提供者名稱 / 姓名、地點等。請將可能有助於我們瞭解您申訴事項的任何文件副本寄至以下所列地址，或將文件傳真至 1-866-704-3420 (標準) 或 1-801-994-1083 (特急) (以上為醫療專用)，及 801-994-1345 (標準) 或 801-994-1058 (特急) (以上為藥房專用)。/ 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.

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☐ 如果您有附上其他頁面，請勾選此方框。/ If you attach other pages, please check this box.

## 給會員或您的代表的通知

加州健康護理管理局負責管理健康護理服務計劃。如果您想對健保計劃提出申訴，首先應致電您的健保計劃，電話 **1-800-624-8822** 或聽力語言殘障服務專線 (TTY) **711**，並使用您健保計劃的申訴流程，之後才與管理局聯絡。使用此申訴程序並不會妨礙您的任何潛在法定權利或可能可以使用的救濟措施。如果您因申訴案件涉及緊急狀況、健保計劃未妥善處理或超過 30 天仍未解決而需要協助，您可致電管理局尋求協助。您也可能有資格接受獨立醫療審查 (Independent Medical Review, IMR)。如果您符合獨立醫療審查 (IMR) 資格，則獨立醫療審查 (IMR) 流程將會針對健保計劃對提議的服務或治療是否為醫療上所必需、實驗性質或研究性質的治療是否屬於承保範圍，以及有關急診或緊急醫療服務付款爭議而做成的醫療決定，進行公正無私的審查。管理局也設有免付費電話 (**1-888-466-2219**) 和供聽語障人士使用的聽力語言殘障服務專線 (TDD) (**1-877-688-9891**)。管理局網站 **www.dmhca.gov** 提供網上投訴表、獨立醫療審查 (IMR) 申請表以及說明。/ 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 **1-800-624-8822** or TTY **711** and use your health plan's grievance process before contacting 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 line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhca.gov** has complaint forms, IMR application forms and instructions online.

如果您是聯邦員工，您的申訴權要透過人事管理局 (Office of Personnel Management, OPM) 行使，而非健康護理管理局 (DMHC)。請參閱您的聯邦員工健康福利 (Federal Employees Health Benefits, FEHB) 方案手冊，其中說明您可於要求聯合健康保險 (UnitedHealthcare) 複核初始拒絕或否決決定後，要求人事管理局 (OPM) 審查拒絕決定。人事管理局 (OPM) 將裁決聯合健康保險 (UnitedHealthcare) 在拒絕您的請款或服務要求時，是否正確應用我們的合約條款。請將您的審查要求寄至：Office of Personnel Management, Office of Insurance Programs Contracts Division 3, 1900 E Street NW, Washington, DC 20415-3630。 / 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.

簽名/ SIGNATURE	
您的簽名/ Your Signature	日期/ Date
代表簽名/ Signature of Representative	日期/ Date

請簽名後郵寄或傳真至/ Please sign and MAIL or FAX to :

ATTN: Appeals and Grievances Department  
P.O. Box 31270 Salt Lake City, UT 84131

傳真/ FAX :

醫療/ Medical 1-801-938-2100 (標準/ standard)  
1-801-994-1083 (特急/ expedited)  
藥房/ Pharmacy 1-801-994-1345 (標準/ standard)  
1-801-994-1058 (特急/ expedited)