

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