

Grievance Form for Managed Care Members

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. If you want to file, please use this form. 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 through our Appeals Department. There is a process you need to follow to file a grievance. UnitedHealthcare, by law, must give you an answer within 30 days. If you have any questions, or prefer to file this grievance 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	1	MI	Date of Birth	
Address	Apt #	City	State	ZIP	
Home Telephone		Work Telephone	<u> </u>	Extension	
If someone other than the member is fi	ling this griev	vance, please provide the	following informa	ition:	
Name		Daytime Telephone			
Relationship to Member		,			
Address	Apt #	City	State	ZIP	
Please describe your complaint. Be sure to involved. Please send copies of anything that documents to 1-801-938-2100 stanta 801-994-1345 pharmacy stanta	t may help us u	understand your grievance to expedited 1-801-994	the address listed I-1083 for me	below or fax the edical and	
☐ If you attach other pages, please check t	his 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 **1-800-260-2773 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