CALIFORNIA

UnitedHealthcare®

UnitedHealthcare Benefits Plan of CA 的申訴表/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.

您有權對於您的任何醫療護理或服務提出正式投訴。您可以在收到初始裁決後 180 個日曆日內，針對服務拒絕決定或遭到拒絕的請款，使用此表格透過上訴和申訴部提出申訴。聯合健康保險將於 5 個日曆日內確認收到，針對標準審查，將於 30 個日曆日內提供答覆。如果您的問題具急迫性，聯合健康保險必須在 3 個日曆日內將決定告訴您。倘若您的問題對您的健康具有嚴重威脅，必須迅速解決，即屬於具急迫性。您也可以在網站 benefits.surest.com 使用網上申訴表提出申訴，或將此表格郵寄至以下地址。如果您有任何疑問，或想以口頭方式提出此申訴，敬請致電聯合健康保險客戶服務部，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 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.

參加註冊或會員卡號碼/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)/MI	出生日期/Date of Birth
地址/Address	門牌號碼/ Apt #	城市/City	州/State	郵遞區號/ZIP
住家電話/Home Telephone		公司電話/Work Telephone		分機/Extension

如果是填寫此申訴表的人不是會員本人，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		日間電話號碼/Daytime Telephone		
與會員的關係/Relationship to Member				
地址/Address	門牌號碼/ 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書，指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.

請說明您的申訴/DESCRIBE YOUR GRIEVANCE

請說明您的投訴。請務必要填寫與事件相關的具體日期、時間、相關人士姓名和醫療護理提供者的姓名 / 名稱、地點等。請將可能有助於我們瞭解您的申訴的任何資料副本寄送至以下所列地址，或將文件傳真至 (醫療相關) 1-801-938-2100 (標準個案) 或 1-801-994-1083 (特急個案)；(藥房相關) 801-994-1345 (標準個案) 或 801-994-1058 (特急個案)。/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.

☐ 如果您附加額外頁面，請在此方框打勾。/If you attach other pages, please check this box.

給會員或您代表的通知/Notice to the Member or Your Representative

California 健康護理管理局負責管理健康護理服務計劃。如果您想對您的健保計劃提出申訴，首先應致電您的健保計劃，電話 **1-866-683-6440** 或聽力語言殘障服務專線 (TTY) **711**，使用您健保計劃的申訴流程，之後才與管理局聯絡。使用此申訴程序將不會使您喪失任何潛在法定權利或您可能可以使用的救濟措施。如果您需要幫忙處理涉及緊急狀況的申訴、您的健保計劃解決申訴的方式無法讓您滿意，或申訴超過 30 天仍未解決，您可致電管理局取得協助。您可能還符合獨立醫療審查 (Independent Medical Review, IMR) 的資格。如果您符合獨立醫療審查 (IMR) 資格，獨立醫療審查 (IMR) 流程進行時會對健保計劃有關建議服務或治療的醫療必要性所做的醫療決定、對實驗性質或研究性質治療的承保決定，及對急診或緊急醫療服務的付款爭議，進行公正的審查。管理局也設有免付費電話 **(1-888-466-2219)**，並為聽語障人士提供聽力語言殘障服務專線 (TDD) **(1-877-688-9891)**。管理局的網站 **www.dmhc.ca.gov** 有提供線上投訴表、獨立醫療審查 (IMR) 申請表及相關說明。/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 **1-866-683-6440** 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.

如果您是聯邦政府員工，您有權透過人事管理局 (Office of Personnel Management, OPM) 提出申訴，而非向健康護理管理局 (DMHC) 提出。請參閱您的聯邦員工健康福利 (Federal Employees Health Benefits, FEHB) 計劃手冊，其中載明您可以在要求聯合健康保險複核初始否決或拒絕決定後，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公司在拒絕您的請款或服務要求時，是否正確適用我們的合約條款。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

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

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

傳真：/FAX:

醫療相關/Medical 1-801-938-2100 (標準個案/standard)
1-801-994-1083 (特急個案/expedited)

藥房相關/Pharmacy 1-801-994-1345 (標準個案/standard)
1-801-994-1058 (特急個案/expedited)