

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。您也可以在此網站 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 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.

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 31393 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)