CALIFORNIA

UnitedHealthcare®

UHC of California 的申訴表/Grievance Form for UHC of California

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。您可以在收到拒絕服務或拒絕請款的初始裁決起 180 個日曆日內，透過我們的上訴和申訴部提交申訴。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。您的問題緊急是指您的健康受到嚴重威脅，因此必須快速解決。您也可以在網站 www.myuhc.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 1-800-624-8822，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 www.myuhc.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 1-800-624-8822 or TTY 711, Monday through Friday, 7 a.m. to 8 p.m. PST.

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	公司電話/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。/
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 1-866-704-3420.

☐ 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/NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE

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起申訴，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利用的救濟措施。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，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)** 和供聽障和語障人士使用的**聽力語言殘障服務專線(**TDD**) (1-877-688-9891)** 。管理局網站 **http://www.dmhc.ca.gov** 提供網上投訴表、獨立醫療審查 (IMR) 申請表和說明。/

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 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 line **(1-877-688-9891)** for the hearing- and speech-impaired. The department's internet website **http://www.dmhc.ca.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 MS. CA 120-0446
P.O. Box 6107
Cypress, CA 90630-9972
FAX: 1-866-704-3420

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