



# Appeal and Grievance Form

Use this form to file an appeal (request for us to reconsider our decision) or grievance (complaint) related to your UnitedHealthcare Medicare Plan (excluding Medicare Supplement). Please type or print in dark ink.

## Member information

Full name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

UnitedHealthcare member ID number \_\_\_\_\_

Date of birth (MM/DD/YY) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**You will need to complete the Appointment of representative section of this form if you're completing for the member.**

## What is the issue?

Check a box below to tell us what your issue or concern is about:

- A medication (prescription drug)
- A medical service (medical care or equipment)
- An issue not related to a specific medical service or medication

### Provide the details below:

Service or medication \_\_\_\_\_

Provider (doctor, facility, prescriber) name \_\_\_\_\_

Have you already received the medical service or medication?  Yes  No

Service date (MM/DD/YY) \_\_\_\_\_

Claim number (if applicable) \_\_\_\_\_

**Please tell us what happened.** Be as specific as possible about what happened and who was involved. Include all dates of service and contact with UnitedHealthcare employees, healthcare providers, or pharmacies. You may attach extra pages if you need more space. Be sure to include all pages when you send this form.

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**What results do you want from us?** (Examples include paying for medical care or a drug, investigating a grievance, etc.) Please tell us below.

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**What additional documents have you attached?**

- |  |  |
|--|--|
| <input type="checkbox"/> Receipt(s)      | <input type="checkbox"/> Letter from your provider |
| <input type="checkbox"/> Medical bill(s) | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Medical records | <input type="checkbox"/> Other                     |

**Does your appeal need to be expedited?** Expedited (fast) appeals are only for services that haven't been provided yet and only if you and your doctor believe that waiting for a decision under the standard timeframe will place your life, health, or ability to regain function in serious jeopardy. Expedited appeals are resolved within 72 hours of when we receive them.

- Please check this box if you need an expedited decision within 72 hours.

**Appointment of representative**

If you are the member completing this form and acting on your own behalf, you can skip this section. Fill out the section below only if you are not the member and you are submitting the form on behalf of the member. **Note:** If you are a provider or legal representative, you will need to fill out a separate Appointment of Representative Form.

**Section I: Appointment of representative**

I, \_\_\_\_\_ (member name) appoint  
\_\_\_\_\_ (representative name) to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative below.

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**Signature of Party Seeking Representation (the member)      Date**

**Section II: Acceptance of appointment**

I, \_\_\_\_\_ (representative name), hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

**Representative information**

Full name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Phone number (with area code) \_\_\_\_\_  
 Relationship to the member \_\_\_\_\_

\_\_\_\_\_  
**Signature of authorized representative** **Date**

**Timeframes for response**

Below are the processing timeframes in which you will receive a response to this appeal or grievance.

Type of appeal or grievance	Response time
Expedited (fast) appeal (medication or medical service)	72 hours
Standard medication “authorization” appeal <b>Example:</b> You need pre-approval for a medication.	7 calendar days
Standard medication “claim” appeal <b>Example:</b> You already have the medication.	14 calendar days
Standard medical service “authorization” appeal <b>Example:</b> You need pre-approval for a medical service.	30 calendar days
Standard medical service “claim” appeal <b>Example:</b> You already received the medical service.	60 calendar days
Expedited (fast) grievance <b>Example:</b> We determined that your appeal doesn’t qualify as an expedited appeal or we’ve taken an extra 14 calendar days to resolve your appeal and you disagree with these actions.	24 hours
Standard grievance <b>Example:</b> You are dissatisfied with the quality of service or care that the plan or a provider gave you.	30 calendar days

## **Ready to send the completed form?**

### **Medical Services Appeals and Grievances**

UnitedHealthcare  
Appeals and Grievances Department  
P.O. Box 6106, MS CA124-0157  
Cypress, CA 90630

Standard Fax: 1-888-517-7113  
Expedited Appeal Fax: 1-866-373-1081

### **Medication (prescription) Appeals and Grievances**

UnitedHealthcare  
Appeals and Grievances Department  
P.O. Box 6106, MS CA124-0197  
Cypress, CA 90630

Standard Fax: 1-866-308-6294  
Expedited Appeal Fax: 1-866-308-6296

### **Questions? We're here to help.**

If you have questions, please call the toll-free Customer Service number on the back of your member ID card.

Thank you for taking the time to complete this form. If we have more questions, we will contact you.