UnitedHealthcare
Community Plan

Your Rights
Complaint (Grievance) and Appeal

We hope being a UnitedHealthcare Community Plan member will be trouble-free and easy for you. We realize sometimes you may want to tell us about a problem or concern.

Examples of Grievances:

- You are unhappy with the care or service your doctor is giving you.
- You are unhappy about service you receive from UnitedHealthcare Community Plan staff.
- The doctor you want to see is not a UnitedHealthcare Community Plan doctor.
- You are receiving a bill for a service that should be covered by UnitedHealthcare Community Plan.

To tell us about a grievance, call or write our Customer Service department. You will get a response within 90 days.

It is possible that you might have a more serious concern that requires medical review. This type of concern is called a "Formal Appeal."

Examples of Formal Appeals:

- The denial or limited approval of a service that was approved in the past.
- The reduction, suspension or termination of a service that was approved in the past.
- The failure to give services in a timely manner.
- The failure of UnitedHealthcare Community Plan to act within the established time frames for a grievance and appeal to be completed.
- Benefits or claims payment, handling or reimbursement of health care services.
- The denial, in whole or in part, of payment for a properly approved and covered service.

The following information explains your Formal Appeal rights in the order that these rights should be followed:

FIRST STEP – Formal Appeal with UnitedHealthcare Community Plan:

Formal Appeals

If UnitedHealthcare Community Plan denies, reduces or terminates a medical service, a denial letter is created. The letter is sent to you and the provider who is asking for the service. It includes the following information:

- The specific reason(s) for the denial;
- The benefit, guideline, rule or other measure used to make the denial decision;
- Your right to ask for a copy of the benefit, guideline, rule or other measure used to make the denial decision; including access to records and other information used in the denial decision. You can request a copy at no cost to you.
- A description of the appeal process. This should include the right to have someone represent you. It should also include the right to send written comments, documents or other information about the appeal. This should also have the time frames for deciding appeals. The provider is also sent this notice of appeal rights.
- Your right to have benefits continue until the appeal is resolved. The denial letter will explain how to request continuation of your benefits and when you may be required to pay the costs of those services.
- A description of a fast appeal process if the denial is an urgent pre-service or urgent concurrent denial.
- A plan physician advisor is available to discuss the denial determination with the provider. The plan advisor is chosen based on the type of review (e.g., physician or chiropractor).

UnitedHealthcare
Community Plan

Your Rights
Complaint (Grievance) and Appeal

Receipt of services

If you file any type of Formal Appeal for services that were discontinued, reduced or changed, you may continue to receive those services/items during your appeal. The Formal Appeal must be hand-delivered or postmarked within 10 days from the date on the written notice of decision. You will continue to receive the service/items at the previously authorized level until the Formal Appeal is resolved.

You can file a Formal Standard or Expedited Appeal by Calling or Writing:

UnitedHealthcare Community Plan
Grievance and Appeals Department
PO Box 30991
Salt Lake City, Utah 84130-0991
1-800-903-5253

- You or your representative, including an attorney may submit a Formal Appeal up to 60 days after the date on the notice of the adverse action.
- You or your representative may submit a Formal Expedited Appeal within 10 days of the adverse action.
- If you need help filing a Formal Appeal, our UnitedHealthcare Community Plan Appeal Coordinator will help you.
- The appeal coordinator will send you an Appeal Acknowledgment Letter.
- If someone else asks for a Formal Appeal on your behalf, we will need your written approval to conduct the Formal Appeal.

You must give us the following information:

- Your **name**
- The number on your UnitedHealthcare Community Plan card
- The **kind of care** you want
- The **reason** you want to appeal
- Your **mailing address**
- The name of the person we should call if we have questions about your appeal
- A **daytime phone number**

If you have not gotten the service yet:

- We will review your Formal Appeal.
- You will get an answer in writing within 30 calendar days.
- If more time is needed and it will benefit you, UnitedHealthcare Community Plan may ask you for 14 more calendar days.
  - We can only ask you for more days one time.

Expedited Formal Appeal

If your problem is so urgent that you need a decision about your care very quickly you or your representative must file an Expedited Appeal within 10 days of the adverse action. If the usual 30-day time frame for a Formal Appeal would cause serious harm to your life or health, your doctor must support this. You can ask for an Expedited Appeal 24 hours a day, 7 days a week. This can be either orally or in writing. You will have a decision about your care within 72 hours.

If you already got the service:

- We will review your Formal Appeal.
- You will get an answer in writing within 30 calendar days.
- If more time is needed and it will benefit you, UnitedHealthcare Community Plan may ask you for 14 more

calendar days. This is if more time is needed and it will benefit you.
- We can only ask you for more days one time.

In some cases, a UnitedHealthcare Community Plan Member Appeal Committee hearing will be held.
- You or your representative have the right to appear before the Appeal Committee to present the appeal.
- The Appeal Committee completes its review of the appeal as fast as possible. This will be done no more than 30 days from receiving of the appeal request.
- If UnitedHealthcare Community Plan sees a need for more information and it is in your best interest the time frame to resolve the appeal will be extended up to 14 calendar days. UnitedHealthcare Community Plan will notify you in writing to explain the reason for the delay.
- The Committee resolves the appeal and makes a final written decision. Forms will be included should you want to request a Fair Hearing or External Review. The process for these reviews is outlined later in this notice.

UnitedHealthcare Community Plan Assistance

UnitedHealthcare Community Plan provides the following assistance:
- If you have disabilities UnitedHealthcare Community Plan will provide assistive services to assist with presenting your case when requested. This is at no cost to you.
- Qualified sign language interpreters, TTY/TDD for telephone inquiries or other commonly accepted alternative forms of communication.
- Information to support UnitedHealthcare Community Plan's stance in a format that you can understand to discuss and/or refute.
- Assistance in copying and presenting documents and other evidence for review by UnitedHealthcare Community Plan.
- UnitedHealthcare Community Plan appropriate plan staff to represent you.
- Provide you language interpreter service when requested. This is at no cost to you.
- Provide reasonable opportunity for you to present evidence and allegations of fact or law in person as well as on the telephone and/or in writing with accommodations provided by UnitedHealthcare Community Plan.

SECOND STEP – Fair Hearing and/or External Review

Fair Hearing

In addition to other rights, you may request a Fair Hearing. This may be done only after you have filed a Formal Appeal of an adverse action and the decision has been upheld. You have 120 Days from the date on the Formal Appeal final resolution notice to request a Fair Hearing with the Department of Health and Human Services Administrative Law Tribunal. You may mail the request form sent with the denial notice to:

Michigan Administrative Hearings – System for the Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909-7695

A form to make a Fair Hearing request will be included with a final adverse determination letter.

For questions about requesting a Fair Hearing you may call 1-877-833-0870

External Review

In addition to other rights, you may request an External Review from the Department of Insurance and Financial Services (DIFS). This is only after you have filed a Formal Appeal of an adverse action and the decision has been upheld. You have 127 days from the date on the final adverse determination letter to request an External Review under the Patient's Right to Independent Review Act (PRIRA).

UnitedHealthcare
Community Plan

Your Rights
Complaint (Grievance) and Appeal

You, your personal representative or your doctor can also request an Expedited External Review decision, from the (DIFS) at the same address below. This can be done immediately after filing with UnitedHealthcare Community Plan. You will have a decision about your care within 72 hours.

1. A form to make an External Review request will be included with a final adverse determination letter.
2. All requests for an External Review, expedited or otherwise, may be mailed to the address below:

DIFS – Office of General Counsel – Appeals Section

(by mail)
P.O. Box 30220
Lansing, MI 48909-7720

(by courier/delivery)
530 W. Allegan Street, 7th Floor
Lansing, MI48933

Fax: **517-284-8838**

External review requests, expedited or otherwise, may also be called in at the phone number below:
Phone: **1-877-999-6442**

External review requests, expedited or otherwise, may also be called submitted online.
This can be done at the web address below:
https://difs.state.mi.us/Complaints/ExternalReview.aspx

REQUEST FOR STATE FAIR HEARING

Michigan Department of Health and Human Services
Michigan Administrative Hearing System
PO Box 30763
Lansing, MI 48909
Telephone Number: 800-648-3397 Fax: 517-763-0146

This form is for enrollees in a Managed Care Health Plan, MI Health Link* Plan, Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), Healthy Kids Dental Health Plan or MI Choice Waiver Program

SECTION 1 – To be completed by the PERSON REQUESTING A STATE FAIR HEARING

Enrollee Name	Enrollee Telephone Number		Enrollee Social Security Number
Address (No.& Street, Apt. No.)	City	State	Zip Code
Enrollee or Legal Guardian Signature	Enrollee Medicaid ID Number		Date Signed

☐ Managed Care Health Plan ☐ MI Health Link (*for Medicaid benefits only) ☐ CMHSP/PIHP
☐ Healthy Kids Dental health plan ☐ MI Choice Waiver

Name of Health Plan, CMHSP/PIHP or Waiver Agency that took the action:

Date of Notice of Appeal Decision (please include a copy of the notice):

☐ As of today's date, I have not received a Notice of Appeal Decision. I sent in an Internal Appeal on: ____________

I am asking for a State Fair Hearing because: Use additional paper if needed.

____

____

____

____

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing?

☐ **No**

☐ **Yes** (If yes, please explain here.) ______________________________

SECTION 2 – Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing?

☐ **No**

☐ **Yes** (If Yes, have the representative complete and sign Section 3.)

SECTION 3 – Authorized Hearing Representative Information

Name of Representative (Please Print)	Representative Telephone Number		Relationship to Enrollee
Address (No.& Street, Apt. No.)	City	State	Zip Code
Representative Signature	Date Signed		

SECTION 4 – To be completed by the AGENCY involved in the action being disputed by the enrollee

Name of AGENCY UnitedHealthcare Community Plan			AGENCY Contact Person Name Janice Balog, Legal Department
AGENCY Address (No.& Street, Apt. No.) 26957 Northwestern Highway Suite 400			AGENCY Telephone Number 248-331-4332
City Southfield	State MI	ZIP Code 48033	State Program or Service being provided to Enrollee MI Medicaid

This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Administrative Hearing System for the Department of Health and Human Services or www.michigan.gov/LARA >> MI Administrative Hearing System >> Benefit Services

REQUEST FOR STATE FAIR HEARING

This form is for enrollees in a Managed Care Health Plan, MI Health Link Plan (*for Medicaid benefits only), Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), Healthy Kids Dental Health Plan or MI Choice Waiver Program

INSTRUCTIONS

A State Fair Hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services, or one of its contract agencies, that an enrollee believes is wrong.

If you are enrolled in a Managed Care Health Plan, MI Health Link, CMHSP/PIHP, Healthy Kids Dental Health Plan or MI Choice Waiver program you MUST finish their internal appeal process before you can ask for a State Fair Hearing. If you do not receive a Notice of Appeal Decision within the mandated timeframe, you may also ask for a State Fair Hearing. You may also send in your signed hearing request in writing on any paper. This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Administrative Hearing System for the Department of Health and Human Services or www.michigan.gov/LARA >> MI Administrative Hearing System >> Benefit Services.

If you asked for your benefit(s) to continue during the internal appeal process and you want them to continue during the State Fair Hearing process, you must ask for the State Fair Hearing and the Michigan Administrative Hearing System (MAHS) must receive your request within 10 calendar days of the date on the Notice of Appeal Decision.

General Instructions:

- Read ALL instructions before completing the attached form.
- This form should not be used for a request for a hearing related to:
  - Public Assistance (Medicaid eligibility, cash assistance, food assistance, or other assistance programs). For these hearing types, you must use form DHS-18, Request for Hearing available online at http://www.michigan.gov/documents/FIA-Pub18_14356_7.pdf .
  - A decision that does not involve a managed care entity on a Medicaid service or your application for a MI Choice Waiver program. For these hearings types you must use form DCH-0092, Request for Hearing for Medicaid Enrollees or Waiver Applicants available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Administrative Hearing System for the Department of Health and Human Services or http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html.
- Please attach a copy of the Notice of Appeal Decision that you received from your managed care organization.
- Complete **Section 1** using the name of the enrollee (even if the enrollee has a guardian or is a minor).
- Complete **Section 2 and 3** only if you want someone to represent you at the hearing.
- Complete **Section 4** if the agency who took the action you are appealing did not fill this out.
- Please make a copy of this completed form for your records.
- If you have any questions, call: **517-335-7519 or** toll free at **800-648-3397**.
- After you complete this form, mail or fax (**no email**) to:

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
PO BOX 30763
LANSING MI 48909
Fax: 517-763-0146

- You may choose to have another person represent you at a hearing.
  - This person can be anyone you choose but he/she must be at least 18 years of age.
  - You MUST give this person written and signed permission to represent you.
  - You may give written permission by checking **Yes** in **Section 2 and having the person who is representing you complete Section 3**. **You MUST still complete and sign Section 1.**
  - Your guardian or conservator may represent you. **A copy of the court order naming the guardian must be included with this request or it cannot be processed.**

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	
If you do not understand this, call the Michigan Department of Health and Human Services at 877-833-0870. Si no entiende esta información comuníquese al Michigan Department of Health and Human Services al 877-833-0870. إذا كنت لا تفهم هذا، فعليك الاتصال بـ Michigan Department of Health and Human Services (وزارة الصحة والخدمات الإنسانية) على رقم الهاتف 877-833-0870.	**877-833-0870**
Completion: Is Voluntary	

FIS 0018 (1/18) Department of Insurance and Financial Services

Health Care Appeals-Request for External Review

You are eligible to request an External Review if ALL the following apply:

- You have exhausted the health carrier's internal grievance process (unless waived because the health carrier did not complete their review within the required time).
- The request is within 127 days of receipt of a final adverse determination.
- The patient was covered on the date of service.
- The health care service appears to be a covered benefit.

The following types of policies are NOT eligible for review: Medicare supplement, disability income, hospital indemnity, specified accident, credit, long term care, and non-governmental self-funded plans.

You are responsible for submitting:

- A copy of the final adverse determination from the health carrier
- Pertinent documentation, such as bills, explanations of benefits, medical records, correspondence, statements from doctors, research material that supports your position, etc.

Note: It is your responsibility to submit medical records. The Department of Insurance and Financial Services does not contact medical sources.

Always send copies. Never send original documents.

1. Patient Name | Name of INSURED person

Name of Health Carrier (HMO, BCBSM, Health Insurer)

Policy number | Group number *(if applicable)* | Claim number *(if applicable)*

Dates service was received or requested — *If service was received, enter date received. If not, enter date service was requested.*

Physician and medical facility involved.

2. Statement of request: Provide a brief explanation of the problem and the resolution you are seeking. Describe the medical services requested or received.*

*Form FIS 2326 (http://www.michigan.gov/documents/difs/FIS_2326_600931_7.pdf) **should be included with requests involving experimental or investigational denials. Please return the form completed and signed by your treating provider to DIFS within 30 days.**

3. EXPEDITED External Review Requirements *(if you are not requesting an expedited external review, or your request doesn't meet the conditions below, skip to Part 4)*

The following conditions must be met:

- An expedited INTERNAL review has been requested AND
- The request is filed within 10 days of receipt of adverse determination AND
- A physician substantiates the medical condition involved in the adverse determination is serious enough to jeopardize the life or health of the covered person.

My request meets these requirements. By completing items (3a.) and (3b.) below, I am requesting an Expedited External Review.

(3a.) Date you requested an expedited INTERNAL review ____________________

(3b.) Name and phone number of substantiating physician: ____________________

☐ I have included a letter from my physician.

4. This request is being filed by *(choose one)*

☐ **The patient**-*provide patient's contact information in part 5*

☐ **The patient's parent (if patient is a minor child); or the patient's legal guardian**-*provide parent or legal guardian's contact information in part 5*

☐ **A representative authorized by the patient**-*provide authorized representative's contact information in part 5.*

5. Contact information for person filing this form

Name of Patient, Parent, Legal Guardian or Authorized Representative

Address

City | State | Zip

Daytime phone number | Evening phone number

If you are not the patient, what is your relationship to the patient?

If person filing is NOT the patient or the patient's parent or the patient's legal guardian, the patient must designate the representative by reading and signing statement in part 6 below:

6. Patient authorization statement

I authorize the person named in Part 5 to act as my authorized representative in this External Review.

Signature of Patient | Date

7. Authorization to review medical information

I authorize the Department of Insurance and Financial Services (DIFS), the Independent Review Organization, the health carrier involved, and any other health care provider needed to review protected health information and records pertaining to this external review.

Signature of Patient | Date

8. Send your Request for External Review to

DIFS - Office of General Counsel - Appeals Section

(by mail)	*(by courier/delivery)*
P.O.Box 30220	530 W. Allegan Street, 7th Floor
Lansing, MI 48909-7720	Lansing, MI 48933
Fax: 517-284-8838	Phone: 877-999-6442

(by email) DIFS-HealthAppeal@michigan.gov

P.A. 251 of 2000 as amended, authorizes the Director to review requests for external review. Submission of this form is required to request an external review by the Director of the Department of Insurance and Financial Services.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY **711**, 8:30 a.m. – 5:30 p.m., Monday – Friday.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY **711**, 8:30 a.m. – 5:30 p.m. Monday – Friday.

CSMI20MC4884703_000

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-903-5253, TTY 711**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-903-5253, TTY 711**.

ملحوظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم **1-800-903-5253** الهاتف النصي **711**.

注意：如果您說中文，您可獲得免費語言協助服務。請致電 **1-800-903-5253**，
或聽障專線 **(TTY) 711**

MADETA: en maswtat lishana Aturaya, eten tishmiishta d lishana qa hayarta quray. Makhber **1-800-903-5253, TTY 711**.

LƯU Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi số, **1-800-903-5352, TTY 711**.

VËMENDJE: Nëse flisni shqip, keni në dispozicion shërbime asistence gjuhësore pa pagesë. Telefono **1-800-903-5253, TTY 711**.

참고: 한국어를 하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. **1-800-903-5253, TTY 711**로 전화하십시오.

মন ন গ: দ আপদ ব ঙ লী ভ ষ য় কথ বনল , তনব আপ র জ ভ ষ সহ য়ত পদরুনসব দব ম নল লভ হনব। ফ করু **1-800-903-5253** মবনর **TTY 711**.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z usługi bezplatnej pomocy jezykowej pod numerem telefonu **1-800-903-5253, TTY 711**.

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachendienste zur Verfügung. Wählen Sie **1-800-903-5253, TTY 711**.

ATTENZIONE: se parla italiano, Le vengono messi gratuitamente a disposizione servizi di assistenza linguistica. Chiami il numero **1-800-903-5253, TTY 711**.

ご注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。電話番号**1-800-903-5253**、または**TTY 711**（聴覚障害者・難聴者の方用）までご連絡ください。

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по тел. **1-800-903-5253, TTY 711**.

PAŽNJA: Ako govorite srpsko-hrvatski, možete dobiti besplatnu pomoć za usluge jezika. Pozovite **1-800-903-5253, TTY 711**.

ATENSYON: Kung nagsasalita ka ng Tagalog, may magagamit kang mag serbisyo ng pantulong sa wika, nang walang bayad. Tumawag sa **1-800-903-5253, TTY 711**.