加州專用/CALIFORNIA

UnitedHealthcare®

PacifiCare®

Managed Care 會員申訴表格/ Grievance Form for Managed Care Members

Medicare Advantage 會員請注意 — 請勿填寫本表格。/Attention Medicare Advantage members – do not complete this form.

您有權針對您的醫療照護或服務提出正式的申訴。如果您想提出申訴，請使用這份表格。提出申訴時，您必須遵守相關程序。根據法律規定，PacifiCare 必須在 30 天內回覆您。如果您有任何問題，或者是偏好提出口頭申訴，歡迎於星期一至星期五上午 7 時到晚上 9 時致電 PacifiCare 客戶服務部：1-800-624-8822 或 1-800-422-8833 (聽語障專線)。如果您認為等候 PacifiCare 回覆會對您的健康造成損害，請於致電時要求「快速審查」。/You have the right to file a formal grievance about any of your medical care or services. If you want to file, please use this form. There is a process you need to follow to file a grievance. PacifiCare, by law, must give you an answer within 30 days. If you have any questions, or prefer to file this grievance orally, please feel free to call PacifiCare Customer Service at 1-800-624-8822 or 1-800-422-8833 (TDHI), Monday through Friday, 7 a.m. to 9 p.m. If you think that waiting for an answer from PacifiCare will hurt your health, call and ask for an "Expedited Review."

最新個人資訊（請工整填寫）/CURRENT PERSONAL INFORMATION (please print or type)

投保或會員卡號碼/Enrollment or Member ID #	雇主或團體名稱/Employer or Group Name		
姓氏/Last Name	名字/First Name	中間名/MI	生日/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

非會員之個人提出申訴時，請提供下列資訊/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，您必須提交代表授權，指出您可以代表會員提出抱怨。/Due to privacy laws, you will be required to submit authorization of representation indicating you can file a complaint on behalf of the member.

請說明您的申訴內容。/DESCRIBE YOUR GRIEVANCE

請說明您的抱怨內容。請務必包含確切日期、時間、人員及醫療服務提供者名稱、地點等相關資訊。請將任何有助於我們瞭解您申訴的文件複本寄至上列地址，或將文件傳真至：1-866-704-3420。/Please describe your complaint. Be sure to include specific dates, times, people and provider's names, places, etc. that were involved. Please send copies of anything that may help us understand your grievance to the address listed above or fax the documents to 1-866-704-3420.

☐ 如果您有加頁，請勾選這個方塊。/If you attach other pages, please check this box.

致會員或會員代表通知/NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE

加州醫療保健計畫管理局負責管理健康照護服務計畫。如果您想對您的健保計畫提起申訴，首先應致電您的健保計畫，電話 **1-800-624-8822**，或 **1-800-422-8833 (聽語障專線)**，透過您健保計畫的申訴程序提起申訴，之後再與管理局聯絡。透過此申訴程序提起申訴並不會妨礙您得享有的任何潛在法律權利或可採取的救濟措施。如果您需要協助處理涉及緊急情況的申訴、您的健保計畫無法以令人滿意的方式解決申訴，或申訴超過 30 天仍未獲得解決時，您可致電管理局請求協助。您可能有資格接受獨立醫療審查 (醫審)。如果您有接受醫審的資格，則醫審程序將會針對健保計畫對有關建議服務或治療是否為醫療所需、是否承保實驗性或調查性的治療，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-HMO-2219)**，以及為**聽語障**人士提供專線電話 **(1-877-688-9891)**。可至管理局網站 **http://www.hmohelp.ca.gov** 下載抱怨表格、醫審申請書和說明。/

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 1-800-422-8833 (TDHI)** 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-HMO-2219)** and a **TDD (1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

如果您是聯邦僱員，您有權透過人事管理局 (OPM) 而非透過加州醫療保健計畫管理局提出申訴。請參閱您的聯邦僱員健康福利 (FEHB) 計畫手冊，其中說明您可在要求 PacifiCare 重新考慮初步否決或拒絕後，要求人事管理局進行審查。人事管理局會判定 PacifiCare 是否依據我們的合約條款來否決您的理賠或服務請求。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 PacifiCare to reconsider the initial denial or refusal. OPM will determine if PacifiCare 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

您本人簽名/Your Signature	日期/Date
代表簽名/Signature of Representative	日期/Date

請於簽名後郵寄或傳真至/Please sign and MAIL or FAX to:

ATTN: Appeals and Grievances Dept.
MS. CA124-0160
P.O. Box 6107
Cypress, CA 90630-9972
傳真/FAX: 1-866-704-3420