

Appeals & Grievances Form

Member Name:		Date of Birth:	
Member ID #:		Medicare Beneficiary Number (MBI):	
Street Address:			
City:		State:	ZIP Code:
Primary Phone Number:		Secondary Phone Number:	

If applicable, please submit an Appointment of Representative form and enter the following.	
Authorized Representative:	Representative Phone Number:

Is this an appeal or grievance? Please select the appropriate box:

<input type="checkbox"/> Grievance	<input type="checkbox"/> Expedited Appeal	<input type="checkbox"/> Standard Appeal (authorization)	<input type="checkbox"/> Standard Appeal (claim/payment)
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- ⇒ **If an appeal**, you must submit this form within 65 days of the date of the denial notification.
- ⇒ **If appealing cost-share liability**, you must submit this form within 65 days of the date on the bill or on the Explanation of Benefits (EOB).

Claim/Payment Appeals Only	
Claim Number(s) Being Appealed:	Provider(s) of Service(s):
Date(s) of Service:	Total Amount in Dispute:
Authorization Appeals Only	
Denied Authorization Number(s) Being Appealed:	Requesting Provider(s):
Servicing Provider(s):	Type(s) of Service:

Please give a detailed summary of your grievance or appeal. Submit additional pages as needed, including copies of denial letters, records, chart notes and any other information that supports your case:

Signature:	Date:
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Mail form to: UCLA Health Medicare Advantage Plan P.O. Box 211622 Eagan, MN, 55121-3622	Email form to: UHMAPappealsandgrievances@mednet.ucla.edu
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If you wish to file an expedited appeal or grievance verbally, please contact Member Services at toll-free number 1-833-627-8252 (MAP-UCLA), April 1st through September 30th, 8am-8pm PST, Monday – Friday. Closed all Federal Holidays. October 1st through March 31st, 8am – 8 pm PST, 7 days a week. Closed Thanksgiving and Christmas Day. TTY users should call the plan at 711 (1-800-735-2929).

What Is a Grievance?

A type of formal complaint, you file a grievance to express dissatisfaction with the operations, activities or behavior of a plan or its contracted providers, whether you request remedial action or not. The Centers for Medicare & Medicaid Services (CMS) — the federal agency that administers Medicare — requires all Medicare Advantage plans to have procedures in place for timely grievance resolution.

Decisions made under the grievance process cannot be appealed.

⇒ Learn more about grievances: <https://cms.gov/medicare/appeals-grievances/managed-care/grievances>

What Is an Organization Determination (Initial Determination)?

It is an approval, denial or any other decision made by your Medicare Advantage (MA) plan or one of its contracted independent physician associations (IPAs) about the:

1. Authorization of or payment for a health care item or service;
2. Amount you're required to pay for an item or service; or
3. Quantity of items or services you can receive.

Anytime you aren't sure if the plan will cover an item or service, you — or your representative or provider on your behalf — can ask for a preservice organization determination (prior authorization). You can make this “request for an organization determination” directly with your MA plan, or through a plan agent or contractor such as an in-network provider.

When a *provider* declines to furnish an item or service, this is not an organization determination but a treatment decision. It's based on the provider's judgment about whether the item or service should be part of your treatment plan or whether they are willing to furnish it, regardless of plan coverage.

⇒ Learn more about organization determinations: <https://cms.gov/medicare/appeals-grievances/managed-care/organization-determinations>

What Is an Appeal (Reconsideration)?

If you disagree with an organization determination, you can request a reconsideration or redetermination by filing an appeal. Your MA plan will revisit your original claim, along with any additional supporting evidence, then approve or deny your request.

⇒ Learn more about appeals (reconsideration): <https://cms.gov/medicare/appeals-grievances/managed-care/reconsideration-advantage-health-plan-part-c>