UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Please Return To: University of Michigan Health Plan
Attn: Appeals
PO Box 30377
Lansing, Michigan 48909-7877

800-832-9186 phone
517-364-8517 fax

UofMHealthPlan.org

APPEAL AND GRIEVANCE FORM

Attach a separate page, if needed. Please retain all records, including a copy of this grievance form, a copy of the bill, and any additional information related to your appeal.

Member Name

Name of Person Completing this Form
If different from member

Relationship to Member

Note: *If you are representing the member in this matter, an* ***Authorization for Use and Disclosure of Protected Health Information form*** *must be on file with us. Contact Customer Service for this form.*

Member ID Number
Include entire number
L0000000-500000000-00

Daytime Phone Number

Evening Phone Number

Best Time to Reach You

Email Address

Street Address

City, State, Zip Code

Is this regarding a service you already received? ☐ Yes ☐ No *If yes, please include a copy of the bill*

Note: *You may appeal a pre-service denial, which is also referred to as a prior authorization request denial.*

Date of Service

Amount Being Billed

Servicing Provider

Reason for Appeal

Date

Signature

We will accept your request for an appeal or grievance if the request is submitted within 180 days from the date of the denial.

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Important Information about your Appeal/Grievance Rights

What if I need help understanding this denial? Contact Customer Service at 800-832-9186.

What if I don't agree with this decision?
You have a right to appeal any decision not to pay for an item or service (in whole or in part).

Who may file an appeal?
You or someone you name to speak for you may file an appeal. We have a form you can complete if you want someone to represent you in your appeal. Contact us if you would like this form.

How do I file an appeal?
Complete the attached form and send along with any additional information within 180 days from the date of notice. You can also send a secure email to us by visiting our website, UofMHealthPlan.org. You do not have to use this form; you can send us a separate letter.

What if my situation is urgent?
If your situation meets the definition of urgent under the law, you will be notified with a decision within 72 hours following receipt of your request. Generally, an urgent situation is one in which your health may be in serious jeopardy, or would jeopardize your ability to regain maximum function while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by faxing or emailing us your request. You may also request an external review at the same time.

What happens next?
We will review your request and send you a written determination within 15 calendar days following receipt of your request. If you disagree with our decision, you will have the option to request an Appeal Hearing. Information about the hearing process will be included in our written determination if necessary. If we continue to deny your request or you do not receive a timely decision, you may have additional external appeal rights.

How do I report suspected fraud?
If you did not receive the services in question or if you suspect fraud or any illegal activity relating to your benefits, let us know. You can either notify us in writing, or by calling the Compliance Hotline, at 866-747-2667. You do not have to identify yourself.

Can I provide additional information?
Yes, you have the right to submit written comments, documents, or other information relevant to the appeal at any point during the review period. If we receive additional information during our review, we will notify you and give you an opportunity to respond.

Can I request copies of the information?
Yes, you have the right to request copies of the criteria on which this decision was based free of charge, by sending a request in writing or by contacting Customer Service at 800-832-9186.

Other Resources to help you
For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (1-866-444-3272).

Independent External Appeal Process
You are permitted to request an independent external review provided that your request is filed within four (4) months from the date receipt of the final hearing decision notice. We will complete a preliminary review determination of your request within 5 business days. We will send you notice of our preliminary review within one business day after completion of the preliminary review. You will receive notice of the final determination on your request within 45 days of receipt.

Additional Appeal Rights
Once you have completed the external appeal process, if you choose to pursue your request, your next option is to exercise your rights under Section 502e (a) of ERISA and or pursue alternative dispute resolutions by contacting the local office of the Department of Labor (DOL) as indicated in your SPD.

LANGUAGE ASSISTANCE

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800.832.9186 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, puede solicitar servicios gratuitos de asistencia lingüística. Llame al 800.832.9186 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المُساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: (TTY: 711) 800.832.9186

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電800.832.9186 (TTY: 711)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter 800.832.9186 (TTY: 711) an.

Italian: ATTENZIONE: Se parla italiano, può disporre di servizi di assistenza linguistica gratuiti. Chiamare il numero 800.832.9186 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800.832.9186 (TTY: 711) まで、お電話にてご連絡ください

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.832.9186 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800.832.9186 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 800.832.9186 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, mayroong mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800.832.9186 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 800.832.9186 (TTY: 711).

Bengali: লক্ষ্য করুনঃ আপনি যদি ইংরেজি ব্যতীত অন্য কোনো ভাষায় কথা বলেন,, তাহলে আপনার জন্য নিখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 800.832.9186 (TTY: 711)।

Albanian: NJOFTIM: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800.832.9186 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su Vam besplatno. Nazovite 800.832.9186 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Syriac:

ܙܘܗܪ̈ܐ: ܐܢ ܐܢܫܬܘܢ ܟܐ ܡܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪ̈ܝܐ، ܟܡܢ ܝܬܘܢ ܕܡܦܠܚܬܘܢ
ܝܠܦܢ̈ܘܬܐ ܕܡܬܪܓܡܢܘܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 800.832.9186 (TTY: 711)