



Appeal Form

Based on federal guidelines, you have 65 days from the date of service, coverage decision or first provider bill to ask for an appeal. **Please fill out this form as best you can and return it to us by mail, email, fax or in person.** If you have medical records, include them with the form. Your records will help us review your appeal. If you have questions, call us at the phone numbers below.

Mailing address

UCare
Member Appeals and
Grievances
PO Box 52
Minneapolis, MN 55440-0052

Physical address

UCare
500 Stinson Boulevard NE
Minneapolis, MN 55413

Email

CAG@ucare.org

Phone

612-676-6841 or
1-877-523-1517
TTY 612-676-6810 or
1-800-688-2534

Fax

612-884-2021 or
1-866-283-8015

Section 1: Good reason

Based on federal guidelines, you have 65 days from the date of service, coverage decision or first provider bill to ask for an appeal. If we get an appeal after 65 days, it's considered late. We'll dismiss the appeal unless you have a valid reason for the delay.

If you couldn't send us your appeal on time, please tell us why:

Section 2: Member information

Member's name:

Date of birth:

Member's address:

City:

State:

ZIP:

Daytime phone:

Member ID #:

Medicare Health
Insurance Claim Number
(HICN) or
PMI #:

Section 3: Appeal information

☐ **Claims denial**

☐ **Service denial**

Have you already had the service?

<p>Date(s) of service:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Provider's name:</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, date(s) of service: _____</p> <p>_____</p> <p>Type of service: _____</p> <p><input type="checkbox"/> Other dispute</p> <p>Other: _____</p> <p>_____</p>
---	---

Section 4: More information about your appeal

Tell us more about your appeal. The information you give us will help with your appeal. If you need more space, include extra pages. You may also attach a statement from your provider, related medical records, denial notices and other papers.

Section 5: Signature

I confirm that the information on this form is true, complete and correct to the best of my knowledge. I understand that UCare will verify the information I give on this form. I agree to send UCare supporting documents or other information if they ask for it.

Member's signature: _____ Date: _____

Member's printed name: _____

Only a member or their authorized representative can file a complaint with UCare. If you aren't the member, you must complete either section 6 or sections 7 and 8.

Section 6: Documentation of a valid representative

I've attached a copy of a valid:

☐ Authorization of Representation Form (CMS-1696)

☐ Power of Attorney (POA) Form

☐ Healthcare Proxy

☐ Estate Form

☐ Other form type: _____

☐ Representative information has been submitted to UCare within the last 12 months.

Information submitted: _____

Date of submission: _____

Section 6/7: Appointment of representative:

Appointment of representative

I, _____ let _____ send this
(print member's name) (print representative's name)

complaint on my behalf, to present evidence to UCare, and receive communication and evidence about this complaint. I understand that personal medical information about my complaint will be shared with my representative.

Member's signature: _____ Date: _____

Section 8: Appointment documentation

Acceptance of appointment

I, _____ (print representative's name), accept the appointment to act on behalf of _____ (print member's name).

Representative's signature: _____ Date: _____

Representative's name:

Relationship to the member:

Representative's address:

City:

State:

ZIP:

Daytime phone:

Notice of Availability

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ልብ ይበሉ:- የአማርኛ ቋንቋ የሚናገሩ ከሆኑ፣ ነፃ የቋንቋ ድጋፍ አገልግሎት ለእርስዎ ቀርቦልዎታል። ተደራሽ በሆኑ ቅርፅ-ቶች መረጃዎችን ለማቅረብ ተገቢ የሆኑ ኢንተር ድጋፍ ሰጪ መሳሪያዎች እና አገልግሎቶችንም እንዲሁ በነፃ ቀርቦዋል። በ 612-676--3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) ይደውሉ.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات المساعدة الإضافية لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. يمكنك الاتصال على الرقم 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

សូមជ្រាបជាដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាភកគិតផ្លែអាចត្រូវបានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏ត្រូវបានផ្តល់ជូនដោយភកគិតផ្លែផងដែរ។ ទូរសព្ទទៅលេខ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

請注意：如果您講粵語，可得免費語言協助服務。還可免費提供適當的輔助工具和服務，能以無障礙格式提供資訊。請致電 612-676-3200/1-800-203-7225 (聽障專線：612-676-6810/1-800-688-2534)。

请注意：如果您说普通话，我们可为您免费提供语言协助服务。此外，我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)。

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) an.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लए नन: शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के लए उपयुक्त सहायक साधन और सेवाएं भी नन: शुल्क उपलब्ध हैं। 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) पर कॉल करें।

TSWM SEEB: Yog tias koj hais tau lus Hmoob, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj siv. Kuj tseem muaj cov kev pab txhawb ntxiv thiab cov kev pab cuam uas tsim nyog los mus muab cov ntaub ntawv qhia paub nyob rau cov qauv uas nkag siv tau dawb thiab. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ໝາຍເຫດ: ການບໍລິການທາງດ້ານພາສາແມ່ນເປັນຮີຣ໌ສໃຫ້ບໍລິການແກ່ທ່ານ. ນອກນັ້ນ, ຍັງມີການບໍລິການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ທ່ານເຂົ້າເຖິງໄດ້ເປັນຮີຣ໌ສ. ໂທ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

HUBACHIISA: Afaan Oromo kan dubbattan yoo ta'e, tajaajila gargaarsa afaanii bilisaan ni argattu. Odeeffannoo bifa dhaqqabamaa ta'een dhiheessuf, gargaarsii fi tajaajiloonni dabalataa mijatoo ta'anis bilisaan ni kennamu. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в других форматах также можно получить бесплатно. Позвоните по номеру 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

FIIRO GAAR AH: Haddii aad ku hadasho Af-Soomaali, adeegyada caawimaada luuqadda ee bilaashka ah ayaa lagu heli karaa. Kaalmooyinka iyo adeegyada dheeraadka ah ee kugu habboon si macluumaadka laguugu siiyo qaabab la isticmaali karo ayaa sidoo kale lagu heli karaa weliba si lacag la'aan ah. Wac 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares adecuados de forma gratuita para facilitar información en formatos accesibles. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga libreng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na karagdagang pantulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Ngoài ra, cũng có sẵn các hỗ trợ và dịch vụ phụ trợ thích hợp miễn phí nhằm cung cấp thông tin ở các định dạng có thể truy cập. Gọi 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

UCare

Attn: Appeals and Grievances

PO Box 52

Minneapolis, MN 55440-0052

Toll Free: 1-800-203-7225

TTY: 1-800-688-2534

Fax: 612-884-2021

Email: cag@ucare.org

Auxiliary Aids and Services: UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services: UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator

Minnesota Department of Human Services

Equal Opportunity and Access Division

P.O. Box 64997

St. Paul, MN 55164-0997

651-431-3040 (voice) or use your preferred relay service