UnitedHealthcare Benefits Plan of California
Form to Request for Review of Cancellation, Rescission, or Nonrenewal of Health Care Service Plan Benefits Contract

In the event you wish to appeal the cancellation, rescission, or nonrenewal, of a plan contract, enrollment or subscription; the subscriber, member (or the legal representative of the member) or the employer may appeal directly to the California Department of Managed Health Care. The appeal may be made electronically, verbally or in writing signed by the subscriber, enrollee (or the legal representative of the subscriber or enrollee) or group contract holder. You are not required to use the form below to initiate a request for review.

Date: _____

To: State of California
Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: (888) 466-2219
TDD: (877) 688-9891
Fax: (916) 229-0465
www.healthhelp.ca.gov

I request that the Director of the Department of Managed Health Care review the cancellation, rescission, nonrenewal of the plan contract, enrollment, or subscription for health plan benefits as follows:

1. Name of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed:

_____
(Full Name - First, Middle and Last Names)

2. Name of subscriber, if different than “1” above:

_____
(Full Name - First, Middle and Last Names)

3. Name of plan: _____

4. Subscriber or Enrollee Account or Identification Number: _____

5. If applicable, the Group Identification Number: _____

6. Date notice of cancellation was received (if known):

   Date of Notice _____
   (Month, Day, Year)

7. Attach copies of:
   (a) The notice of cancellation sent by the plan.
   (b) Any correspondence with the plan regarding the cancellation, rescission, or nonrenewal.
   (c) Proof of payment for the last paid coverage period and date of payment.

8. Do you know why the plan cancelled, rescinded, or did not renew your coverage? If yes, please explain.

☐ Yes ☐ No

_____
_____
_____
_____
_____
_____

9. State why you believe the cancellation, rescission, or nonrenewal is wrong.

_____
_____
_____
_____
_____
_____

10. Explain why you believe that the cause or causes for cancellation described in the notice of cancellation are wrong. Attach copies of any documents that help explain your position.

_____
_____
_____
_____
_____
_____

11. Does the cancellation, rescission, or nonrenewal prevent you or any enrollee covered under the policy from receiving medically necessary health care services? If "yes," please explain:

☐ Yes ☐ No

_____
_____
_____
_____
_____
_____
_____

12. Has the person named in item "11" above, whose health care benefits were cancelled, rescinded, or not renewed, received any medical or health care since the cancellation, rescission, or nonrenewal? If "yes," what services were received and how much did they cost?

☐ Yes ☐ No

_____
_____
_____
_____
_____
_____

Signature of Complainant: _____

Health plan coverage provided by UnitedHealthcare Benefits Plan of California, UHC of California DBA UnitedHealthcare of California or other affiliates.

Administrative services provided by United HealthCare Services, Inc. OptumRx, OptumHealth Care Solutions, Inc. or its affiliates. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

PCA758756-000