CALIFORNIA SCHOOLS VEBA YOUR HEALTH, OUR PURPOSE

Second-Level Appeal Form

If your First-Level grievance or appeal is denied, You or Your Covered Dependent have the right to file a written appeal within sixty (60) calendar days following receipt of the denial of the first level/step appeal. Your second-level appeal will be reviewed, and a written decision will be made by either the Ombudsperson or the External Reviewer within twenty (20) days after it has been received. You must submit a first-level appeal before submitting a second-level appeal.

Instructions

1. The form includes the following information:
   - Case Number
   - Patient Information
   - Describe your Grievance
   - Note – Representative information is case dependent.
2. Send this completed form and all relevant documents to VEBA Direct.

Please keep copies of all items for your records. Examples of relevant documents may include:

- Statements: Premium billing statement or Provider bills
- Proof of payment: Receipts, a copy of the front and back of a canceled check, or credit card statement
- Correspondence: plan notices or enrollee correspondence

Submit

Please submit the finished form by mail or via the online form:

By Mail
California Schools VEBA
c/o Office of the Ombudsperson (VEBA Direct)
1843 Hotel Circle South, Suite 300
San Diego, California 92108

Case Number:
Do not fill out this form if you do not have a case number. The case number can be found on your first-level appeal Acknowledgement Letter or Notice of Adverse Benefit Determination you received from VEBA Direct's TPA (UnitedHealthcare). You must submit a first-level appeal before submitting a second-level appeal. All questions regarding the first-level appeal should be directed to UnitedHealthcare's Customer

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Service at 1-888-586-6365 Monday through Friday, 7:00 am to 9:00 pm. If you are hearing impaired, you may call their toll-free TTY at 1-800-442-8833. All other questions should be directed to VEBA Direct's Advocacy team at 888-276-0250.		
Patient Information		
First name:	Last name:	Middle initial:
Member ID#:	Employer or Group Name:	Birth date: MM/DD/YY / /
Email address:	Daytime Telephone:	Evening Telephone:
Home address:		
City:	State:	ZIP:
Mailing address (if different from Home Address):		
City:	State:	ZIP:
If someone other than the Member is filing this grievance, please provide the following information:		
Name:		
Relationship to Member:		Daytime Telephone:
Address:		
City:	State:	ZIP:
Describe Your Grievance		

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Briefly outline your complaint. Please include specific details including dates, times, people, provider names, places, etc. involved in your grievance. If you have copies of documents, bills, checks, or other correspondences related to this complaint that were not submitted previously or were not considered in the review of the original claim or as part of the first-step/level benefit decision, please include them with this form. Please include a statement regarding the outcome desired and what you believe the VEBA Direct can do to resolve your concern.
□ If you attach other pages, please check this box.

	Are copies of enrollee correspondence with plan attached? (if applicable) □ Yes □ No
Are copies of proof of payment for the last paid coverage period attached? (if applicable) □ Yes □ No	Are copies of plan notices and correspondence received attached? (if applicable) □ Yes □ No
I authorize the below named person to act as my representative in the disposition of this grievance. I understand this authorization will automatically expire upon completion of the appeal or grievance filed on my behalf.	
Your signature:	Date: / /
Signature of representative:	Date: / /

If you need assistance, we're here to help. Please call VEBA's Advocacy team at 888-276-0250. We are available to assist you Monday through Friday, 8:00 a.m. to 5:00 p.m. (PT).