UnitedHealthcare Community Plan

Provider Appeal Request Form

Provider Appeal: Provider dissatisfaction with a claim payment or denial for services not due to a pre-authorization medical necessity denial.
NOTE: For reconsideration, please use the Corrected Claims and Reconsideration Request Form found on our website.

Grievances and Appeals
UnitedHealthcare
P.O. Box 31364
Salt Lake City, UT 84131-0364
Phone: 1-877-236-0826
Non-Urgent Fax: 1-801-994-1082

Patient Name: _____ Insured's Member ID: _____

Provider Name:_____ Provider NPI Number:_____

In-Network ☐ Out-of-Network ☐

Claim Filed On: CMS 1500 ☐ UB 04 ☐

Claim Submission Date: _____ Account Number: _____

Referring Provider: _____ Referral/Authorization Number: _____

Claim Number: _____ Date of Service: _____

Charge Amount: _____

Place of Treatment:

Office ☐ Emergency Room ☐ Inpatient Hospital ☐ Outpatient Services ☐

Home ☐ Skilled Nursing Facility ☐ Other ☐

Please describe the reason for the requested action:

_____
_____
_____
_____