UnitedHealthcare
Community Plan

Appeal Request Form

Instructions: This form is to be completed by Physicians, Hospitals, or other health care professionals who wish to request a clinical appeal of an adverse medical determination or administrative claim made by UnitedHealthcare Community Plan (Do not use this form for Claims Reconsideration requests).

Are you appealing on the member's behalf? [ ] Yes [ ] No

(Please note: If you are requesting to appeal on behalf of a Community Plan member enrolled in the MississippiCAN program you must submit written consent from the member with this request).

Today's Date: ________________________ I am a: [ ] Physician [ ] Hospital [ ] Other Health Care Professional/Service (APRN, DME company, etc.)

Date(s) of Service being appealed ____

PLEASE SEND A COPY OF ALL ADMINISTRATIVE OR MEDICAL RECORDS PERTINENT TO THE EPISODE OF CARE FOR WHICH THE ADVERSE DETERMINATION WAS MADE WITH THIS FORM – THIS INFORMATION IS CRITICAL TO YOUR APPEAL REVIEW.

NOTE: MAIL (No Faxes) Appeal Request Form AND All Pertinent Records concerning the episode of care being appealed to:

UnitedHealthcare
ATTN: APPEALS
P.O. Box 5032
Kingston, NY 12402-5032

PATIENT'S INFORMATION (Please Print):

Patient Name: ____ D.O.B.:__________________________________

UnitedHealthcare Community Plan ID #: ________________________________ Medicaid ID #: ____

PHYSICIAN/HEALTH CARE PROFESSIONAL/FACILITY INFORMATION (Please Print):

Tax Identification Number: ____

Physician / Provider/ Facility Name: ____ NPI #:________________________________

Practice Contact Person: ____

Fax #: ____ Phone #: ____

REASON FOR REQUEST

[ ] The denial or limited authorization of a clinical service

[ ] The reduction, suspension, or termination of a previously authorized clinical service

[ ] The denial, in whole or in part, of payment for a service

[ ] Other (Please Print):

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To check on the status of an Appeal, please call Provider Services: 877-743-8734

NO NEW CLAIMS SHOULD BE SUBMITTED WITH THIS FORM. SUBMIT A SEPARATE FORM FOR EACH CLAIM.