



UnitedHealthcare Community Plan

Reconsideration Request Form

Instructions: This form is to be completed by Home and Community-based providers, Skilled Nursing Facilities, physicians, hospitals, or other health care professionals requesting a reconsideration regarding services rendered to a UnitedHealthcare Community Plan product enrollee.

Date _____ Home and Community based Provider Skilled Nursing Facility
 Physician Hospital Other Health Care Professional (Lab, DME, etc)

First Submission (Claim Reconsideration Request) – As a “First Submission” this request will be handled as a Claim Reconsideration. **Send all Claim Reconsideration requests to:**

UnitedHealthcare Community Plan
P.O. Box 31350
Salt Lake City, UT 84131-0350

(NOTE: It is required that you complete the Claim Reconsideration process before you submit a Request for Appeal.)
Appeals Address
UnitedHealthcare Community Plan
PO Box 31364
Salt Lake City, UT 84131-0364

ENROLLEE INFORMATION

Enrollee Name: _____ D.O.B. _____
Control / Claim #: _____ D.O.S. _____ Billed Amount _____
Enrollee ID #: _____

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION

Tax Identification Number: _____
Physician/Facility Name (as listed on PRA / EOB): _____
Contact Person: _____ Phone Number: _____

REASON FOR REQUEST

1. Previously denied as “Exceeds Filing Time” (*attach valid proof of timely filing, computer generated activity or print screen, EOB statement or letter from another insurance carrier which proves claims were filed timely*)
2. Previously denied for “Additional Information” (*provide description and/or requested documents*)
3. Previously processed, rate applied incorrectly resulting in over/underpayment (*explain below*)
4. Previously processed as “Bundled claim” (*including all supporting information*)
5. Other Comments (*explain below*)

Required Attachments:

- Copy of Provider Remittance Advice (PRA) or EOB
- Claim form (with corrections if necessary)
- Other required attachments as listed above

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

This form is intended to be used to seek review of claims for services provided to UnitedHealthcare Community Plan product enrollees. For review of members enrolled in other benefit plans, please refer to one or more of the following for information on requesting claim reviews: the Web Site for the entity listed on the member's identification card, the Explanation of Benefits for the applicable claim, or www.UnitedHealthcareOnline.com. You may also call the telephone number on the member's identification card for information on how to request claims reviews.

For questions related to the status of Appeals over 30 days please refer to the Customer Service phone number listed in the Provider Administrative Manual or at UHCCCommunityPlan.com