MEMBER APPEAL REQUEST FORM

Member Name: _____

Member UnitedHealthcare ID Number: _____

Mailing Address: _____

City, State, Zip: _____

Phone Number: _____

(Provide the preferred phone number to reach you)

Type of coverage decision you are appealing:

_____ Denied Claim or Service, or

_____ Denied Authorization for Service Not Yet Received

Explain the facts of your appeal. Include specific date(s) of service you are appealing and the name of the provider(s) (doctor, hospital, etc.) involved. Also, explain why the claim or service should be covered. Please attach any documents or medical records that support your appeal.

_____

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_____

I acknowledge that by my signature, I reaffirm that UnitedHealthcare may request medical records related to my appeal.

_____ _____

Signature *(If the member is age 18 or older, s/he must sign and date this form)* Date

Naming an authorized representative:

(If someone other than the member is handling the appeal)

"I *(your name)* _____ appoint

(name of representative) _____

to act as my authorized representative in requesting an appeal from UnitedHealthcare." The authorized representative must also sign and date the form below, unless he/she is an attorney.

_____ _____

Signature of authorized representative Date

Authorized Representative Address: _____

Authorized Representative City, State, Zip: _____

Authorized Representative Phone Number: _____

Mail or fax this completed form and any attached document(s) to the following:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City UT 84131

Fax Number: (801) 994-1082

If you have any questions or need help completing this form, call member services at 1-800-464-9484.