Member Service Request Form Instructions

At UnitedHealthcare, we continuously strive to bring you a higher level of service. Although you are not required to submit this form, completing it will help us address your issue in a timely and thorough manner.

When should I use this form?

You may use this form to submit:

- information requested by UnitedHealthcare
- a question about a claim or your coverage
- a formal review of or a complaint regarding a claim, coverage determination or service received

How do I submit a request?

Please complete the attached form as follows:

Section I: Your information

- Enter the information specific to yourself, as the person completing the form. You may or may not be the person who received medical services. Please remember to also have the patient complete the *Authorization For The Use and Disclosure of Information* form if you are not the patient, enrollee, parent/legal guardian, or provider of service. This form can be obtained from your member Web site, **myuhc.com**® under the link "Claims and Accounts." In some circumstances, state law requires that this form be completed if you are not the patient. We will notify you if your submission requires the completion of this Authorization Form.

Section II: Information from your plan's explanation of benefits, health statement or medical ID card

- The items to be completed in this section can be found on your plan's explanation of benefits (EOB) or health statement received from UnitedHealthcare after your claim was processed or from your Medical ID card.
- The subscriber ID is a nine-digit number.
- The group number is a five- to seven-character number.
- Demographic information such as your address cannot be updated by submitting this form. Please contact your employer with any updates to this information.

Section III: Reason for request

- Check the box that best describes your reason for the submission.
- If you are disputing a decision made by UnitedHealthcare regarding the handling of a claim or a coverage for a health service, or about the quality of the service or care you received, please include additional comments to explain your request or situation. You may attach additional pages as necessary. **Please do not write on the back of the form.**

Section IV: Submitting your request

- **Complete and submit only the form that appears on the following page.** Keep this instruction page for your records, as well a copy of the completed form.
- If your request is related to the handling of a claim, attach a copy of your health statement or EOB for each claim, if available. You may obtain a copy of your EOBs on **www.myuhc.com.**
- If you are submitting additional information requested by UnitedHealthcare, please attach a copy of the letter received requesting this information, if available.
- If you have other documentation or items that may help us understand your request or better explain your situation, please attach these items also.
- If your group number, which is listed on your medical ID card, is **192744, 194422, 197313, 229050, 393476, 401010, 503777, 700406, 707997, 722266, 722267, 722268, 722269, 722270** or **722271**, mail the form with any attachments to:
  UnitedHealthcare Member Inquiry/Appeals
  PO Box 740816 Atlanta, GA 30374-0816.
- **All other group numbers**, mail the form with any related attachments to:
  UnitedHealthcare Member Inquiry/Appeals
  PO Box 30432 Salt Lake City, UT 84130-0432.
- Upon receipt of this form and any supporting documentation, we will send you a written response within the time frame required by your state or employer, but no later than 45 days from receipt of necessary information.

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Member Service Request Form

Date form completed: / /

SECTION I: Your information

Name of person completing this form: Last First MI

Address:

City: State: ZIP: Telephone ( ) Ext:

What is your relationship to the patient?
☐ Subscriber ☐ Parent/Legal Guardian ☐ Provider of Service ☐ Other** _____
***If "other" is checked, please print and have the patient complete the form titled Authorization For The Use and Disclosure of Information and attach it to your request.*

SECTION II: Information from your explanation of benefits, health statement or ID card

Subscriber ID number (nine-digit number): Group/Contract # (five to seven digits)

Member (subscriber) name: Last First MI

Patient name: Last First MI

Patient's date of birth: / /

Address: City State: ZIP:

Date of service: / / Total amount charged: $ (required only if your request is about a claim)

Provider of medical services (as listed on your explanation of benefits or health statement):

SECTION III: Reason for request

☐ I am submitting the additional information requested by UnitedHealthcare. This may include coordination of benefits, full-time student status information, medical records, accident information or other requested information. (Please attach the requested documents along with the letter you received requesting this information, if available.)

☐ I have a question about how a claim was processed, my benefits or available coverage, requirements of my plan, or some other issue. (Please explain below.)

☐ I am requesting a formal review of a decision made by UnitedHealthcare regarding the handling of a claim or coverage for a health service, or I have a complaint regarding a claim, coverage determination or service received. (Please explain below.)

Additional comments: (Required if boxes 2 or 3 are checked above. Attach additional pages if necessary.)
Please do not write on the back of this form.

SECTION IV: Submitting your request

1. Complete this form to the best of your ability. Please do **not** submit new claims to be processed.
2. Attach a copy of your health statement or explanation of benefits, if available, as well as other items that may help us understand your request.
3. Mail this form along with attachments to the PO Box indicated for your group number on the instruction page.