Grievance and appeal form

Member's Name_____ ID # _____

Address _____

Telephone Number (Home)_____ (Work) _____

Please describe your concern in detail using names, dates, places of services, time of day and issues that occurred. If applicable, also state why UnitedHealthcare Community Plan should consider payment for requested services that are not normally covered. Please mail this completed form to the address listed at the bottom.

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(Signature) (Date)

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364