Grievance and Appeal Form

Member's Name ______________________________ ID # ____

Address ____

Telephone Number: (Home) ____________________ (Work) ____

Please choose one of the following:

- ❑ APPEAL — Are you unhappy about a benefit or claim payment decision we made?
- ❑ GRIEVANCE — Are you unhappy about something other than a benefit or claims payment decision we made?

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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Name, Address and Phone number of your Authorized Representative, if any:

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(Signature) (Date)

Member Services
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364