A UnitedHealthcare Company

UMR Post-Service Appeal Request Form

Please fill out the following information when you are requesting a review of an adverse benefit determination or claim denial by UMR. If you are appealing on behalf of someone else, please also include the Designation of Authorized Representative form with this request.

Request information

1. Today's date ____ / ____ / ____ (MM / DD / YY)
2. Patient name _____
3. Patient date of birth ____ / ____ / ____ (MM / DD / YY)
4. Member ID _____
5. Member name _____
6. Plan name _____
7. Date of service of claim ____ / ____ / ____ (MM / DD / YY)
8. Claim control number _____
9. Total billed amount of claim $ _____
10. Provider name _____

11. Are you including medical records with your request? Yes ◯ No ◯

Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file. Medical records consist of office notes, laboratory results, operative notes/reports and medical history.

12. Name, address and phone number of person filling out the form for UMR to contact with any questions:

Name _____ Address _____

Phone number _____

13. Description of dispute

Please mail your completed form along with any supporting medical documentation to:

UMR – Claim Appeals, PO Box 30546, Salt Lake City, UT 84130–0546