A UnitedHealthcare Company

UMR Post-Service Appeal Request Form

Please fill out the below 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.

1. Today's date:	**6. Plan name:**
2. Patient name:	**7. Date of service of claim:**
3. Patient date of birth:	**8. Claim control number:**
4. Member ID:	**9. Total billed amount of claim:**
5. Member name:	**10. Provider name:**

11. Does the document contain medical records requested by UMR? ☐ **Yes** ☐ **No**

Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file.

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 fax or mail your completed form along with any supporting medical documentation to the address listed below.

Fax: 877-291-3248

(Each fax will be reviewed in the order it is received by the Appeals Department)

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