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.

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. Name of person filling out the form: _____

Phone number: _____

12. Description of dispute:

Please fax or mail your completed form along with any supporting medical documentation to the address listed below. Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file.

Fax: 877-291-3248

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