A UnitedHealthcare Company

UMR Post-Service Provider Request Form

Please fill out the below information when you are requesting a review of an adverse benefit determination or claim denial by UMR. Click here to log in and submit your completed form electronically (This feature requires Internet Explorer, versions 8 and later. It does not support Google Chrome or Firefox).

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. 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 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