

Date Faxed ____/____/____

Member Service Request Form

Section I: Member Information

Retiree's Full Name: _____

Patient's Full Name: _____

Patient's Date of Birth: ____/____/____

Subscriber ID Number: _____

What is your relationship to the patient? (Check one) Retiree _____ Spouse _____

If you are not the patient, do you have permission to discuss the patient's medical information? _____
yes/no?

Daytime Telephone Number that you can be reached at, including area code: ____-____-____

Best time of day to contact you at: _____ AM or PM?

Fax Number that we can respond to if you can not be reached by telephone: ____-____-____

Section II Claim Information

Date of Service: ____/____/____ Provider of Service: _____

Claim Number: _____

Section III Reason for Request

Section IV: Submitting your Request

1. This fax line and form can only be used after you have spoken with United Healthcare's Customer Care unit, and are dissatisfied with the resolution of your issue. If you have not previously spoken with United HealthCare about this issue, this form will be returned to you unanswered.
2. Please complete all questions on this form.
3. Fax this form to United HealthCare at 262-953-9129
4. Receipt of your fax will be acknowledged to the retiree by telephone, by the close of the next business day.
5. If United Healthcare is unable to contact you by telephone, we will fax you a request to contact us at your convenience to discuss your issue.
6. As an alternative, you may call us at 1-866-365-9146 for assistance with your issue, or email us at : ATT_Escalation@uhc.com