Claims Project Management Request Form

By submitting this form you agree not to bill the member. This form should be used when you have more than 20 claims. Email the completed form and spreadsheet to ProjectIntake@uhc.com

- Fields with an asterisk ( * ) are required.
- Please be specific when completing the Description of the Issue/Expected Outcome section.
- Provide additional information to support the issue. Don’t include a copy of a claim that was previously processed.

<table>
<thead>
<tr>
<th>*Provider Name:</th>
<th>*Provider Tax ID Number/Medicare ID Number:</th>
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Provider Address:
Contact Name:
Phone:
Fax:
Email:

Provider Type:
- Physician
- Behavioral Health
- Hospital
- Ambulatory Surgery Center
- Skilled Nursing Facility
- Durable Medical Equipment
- Rehab
- Home Health
- Ambulance
- Other: (Please Specify)

Issue Type:
- Claim
- Other: (Please Specify)

Description of the Issue/Expected Outcome:
- Example:
  Care provider expected: $7,200
  6 days M/S at $1,000 per day: $6,000
  Implant at 50 percent: $200
  Prescription 100 percent billed charges: $1,000
  UnitedHealthcare paid: $6,000
  Member copay: $200
  Balance due to care provider: $1,000