Negotiation Request Form

This form is to be completed by physicians, hospitals or other health care professionals.

NOTE:

- Please submit a separate form for each request.
- No new claims should be submitted with this form.
- Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.

You may verify the member's address using the eligibility search function on the website listed on the member's health plan ID card.

☐ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, etc.)

Member Information

Date Form Completed ___________________________________

Member ID	Control/Claim Number	Date of Service		Billed Amount
Member Last Name		First Name		MI
Street Address		City	State	ZIP
Patient: Last Name		First Name		MI

Physician/Health Care Professional Information

Tax Identification Number (TIN)_________________________Phone Number (with area code) __________________________

Email Address ____

Physician or other Health Care Professional Name (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB))

Last Name_________________________________First_________________________________MI _____

Street Address_______________________________City________________________________State_____ZIP __________

Facility/Group Name_________________________________Contact Person _______________________________________

Contact Fax Number (with area code) ______________________________

CONTINUED

Comments:

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Requested Attachments:

- Copy of PRA or EOB.

You may have additional rights under individual state laws. Please review the provider website **uhcprovider.com,** if you need more information.

1183414.0 1/19 ©2019 United HealthCare Services, Inc. 18-10055-A