Care Provider Complaint Form

UnitedHealthcare Community Plan values your feedback. Please use this form to let us know of any issues we can help resolve for you. Within 30 days, we'll send you a letter explaining the complaint resolution. Please submit a separate form for each complaint.

Thank you for helping us improve your care provider experience.

Date:	
You are a: ☐ Home and Community Based Provider (Long-term Services and Supports) ☐ Skilled Nursing Facility ☐ Hospital Care Provider ☐ Primary Care Provider or Specialist ☐ Other Health Care Professional (Lab, DME, etc.)	
Provider Business Name (as listed on provider remittance advice PRA):	
Tax Identification Number:	
National Provider Identification (NPI) Number or Alternate Provider Identification (API) #:	
Contact Person:	Phone:
Email:	
Please describe your complaint or issue:	
How can we resolve this issue for you?	

Please include any written documentation that can help explain your complaint, then send it with your completed complaint form to:

Mail: UnitedHealthcare Community Plan
PO Box 31364
Salt Lake City, UT 84131-0364

Fax: 801-994-1082

This form is not to be used to submit an appeal. Thank you.

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