INSTRUCTIONS

1. Complete all the sections below, and sign where indicated.
   - ✓ Along with the claim, submit COPIES of:
   - ✓ CMS-1500 or UB04
   - ✓ Any medical records or documentation that supports the appeal
2. Relevant sections of the National Correct Coding Initiative (CCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes.
3. Submit form and supporting documentation to the appropriate address below:

Questions? We are here to help! Call the Provider Services Line 1-866-724-9334, Monday-Friday, 8 a.m.-8 p.m. ET

Medical Care - Part C

- UHC Preferred Medicare Advantage FL-0001 (HMO)
- UHC Preferred Medicare Advantage FL-0002 (HMO)
- UHC Preferred Complete Care FL-0003 (HMO C-SNP)
- UHC Preferred Medicare Advantage FL-002P(HMO)

Preferred Care Partners
Appeals & Grievance Department
P.O Box 6106, MS CA124-0157
Cypress, CA 90630-0016

Medical Care - Part C

- UHC Preferred Dual Complete FL-D001 (HMO D-SNP)
- UHC Preferred Dual Complete FL-D01P (HMO D-SNP)

Preferred Care Partners
Appeals & Grievance Department
P.O Box 6106, MS CA124-0187
Cypress, CA 90630-0016

Prescription Drugs - Part D

- All plans

Preferred Care Partners
Appeals & Grievance Department
P.O Box 6106, MS CA124-0197
Cypress, CA 90630-0016

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION:

Tax Identification Number (TIN): ______________________ Phone Number: ______________________

Provider Name: ____

Facility/Group Name: ____

Street Address: ____

Contact Name: ______________________ Email: ______________________

PATIENT INFORMATION:

Member Name: ____________________ Member ID:______________ Date of Birth: ______________

Address: ____

APPEAL NFORMATION:

I wish to submit an Appeal to Preferred Care Partners regarding the denial of the following:

Claim/Authorization: ______________________ Date of Service: ______________________

Denial Reason: ______________________ Total Charges (Claim Appeal): ______________________

Physician providing service (Authorization Appeal):______________________________

Reason for reconsideration:____

____

Signature ______________________ Date ______________________