Preferred Care Partners
A UnitedHealthcare Company

Preferred Care Partners Provider Appeal Request Form

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 & B	Medical Care - Part C&B	Prescription Drugs - Part D
• UHC Preferred Medicare Advantage (HMO) • UHC Preferred Complete Care (HMO C-SNP)	UHC Preferred Dual Complete (HMO D-SNP)	• All plans
Preferred Care Partners Appeals & Grievance Department P.O Box 6106, MS CA120-0360 Cypress, CA 90630-0016	**Preferred Care Partners** Appeals & Grievance Department P.O Box 6106, MS CA120-0360 Cypress, CA 90630-0016	**Preferred Care Partners** Appeals & Grievance Department P.O Box 6106, MS CA120-0368 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 INFORMATION:

I wish to submit an Appeal to Preferred Care Network 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 _____