Care provider complaint form

UnitedHealthcare Community Plan of Texas

We value your feedback. Please use this form to let us know of any issue we can help you resolve. If you have multiple issues, please submit a separate form for each issue. When completing the form, please avoid including protected heath information (PHI) when possible. Within 30 days, we'll send you a letter explaining the complaint resolution.

Thank you for helping us improve your care provider experience.

Please send your completed form and any written documentation that supports your issue to one of the following:

Mail: UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364

Fax: 801-994-1082

Phone: Provider Call Center
888-887-9003
8 a.m.–6 p.m. CT, Monday–Friday

Date:

You are a:

- ☐ Home- and community-based provider
- ☐ Skilled nursing facility
- ☐ Physician
- ☐ Hospital care provider
- ☐ Other health care professional (Lab, DME, etc.)

Provider name (as listed on provider remittance advice [PRA]/explanation of benefits [EOB]):

Tax ID number (TIN):

National Provider Identifier (NPI) number:

Contact person: | Phone:

Email:

Please describe your complaint or issue:

How can we resolve this issue for you?

United Healthcare Community Plan