

INSTRUCTIONS

- 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
- 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.
- Submit form and supporting documentation to the appropriate address below:

Questions? We are here to help! Call the Provider Services Line 1-800-348-5548, Monday-Friday, 8 a.m.-8 p.m. ET

Medical Care - Part C & B

- UHC MedicareMax Medicare Advantage (HMO)
- UHC MedicareMax Complete Care (HMO C-SNP)

Preferred Care Network
Appeals & Grievance Department
P.O Box 6106, MS CA120-0360
Cypress, CA 90630-0016

Medical Care - Part C&B

UHC MedicareMax Dual Complete (HMO D-SNP)

Preferred Care Network
Appeals & Grievance Department
P.O Box 6106, MS CA120-0360
Cypress, CA 90630-0016

Prescription Drugs - Part D

- All plans

Preferred Care Network
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 _____