Delegated risk reconsideration submission

To: UnitedHealthcare Value-Based Reimbursement Risk Reconsideration Team

Please accept this reconsideration request regarding the attached claim. UnitedHealthcare forwarded the claim and supporting information to us for processing. However, we believe the health plan is responsible for this claim. Thank you.

Plan type	Submission method	Delivery address
Commercial	Paper	UnitedHealthcare VBR Issue Resolution Team P.O. Box 31222 Salt Lake City, UT 84131
Medicare Advantage	Paper	**For dates of service prior to Jan. 1, 2026:** UnitedHealthcare VBR Issue Resolution Team P.O. Box 30968 Salt Lake City, UT 84130 **For dates of service Jan. 1, 2026, and after:** UnitedHealthcare VBR Issue Resolution Team P.O. Box 31362 Salt Lake City, UT 84131
Individual and Family Plan (IFP) and Medicaid	Email	**vbrifpdelegateddisputeresolution@uhc.com**

Claim type (choose an item): ☐ Professional ☐ Hospital

Product type (choose an item):			
☐ Medical – transplant	☐ Behavioral	☐ Medical – other	☐ Prescription drug
☐ Dental	☐ Vision	☐ Other: Please provide more information	
☐ Physical health – occupational therapy/physical therapy/speech therapy/chiropractic			

Please enter the required information:*		
ICN (10 bytes):	FLN (15 bytes):	*Member ID:
UnitedHealthcare received date (YYYY/MM/DD):	*Member last name:	*Member first name:
*Date of service from (YYYY/MM/DD):	*Date of service to (YYYY/MM/DD):	Delegate payer ID (5 bytes):

Reason for reconsideration (brief description, 200 characters or less):

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