Care Provider Complaint Form

UnitedHealthcare Community Plan values your feedback. Please use this form to let us know of any issues we can help resolve for you. 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. Please submit a separate form for each complaint.

Thank you for helping us improve your care provider experience.

<table>
<tr><td colspan="2">Date:</td></tr>
<tr><td colspan="2">You are a:
☐ Home and Community Based Providers
☐ Skilled Nursing Facility
☐ Physician
☐ Hospital Care Provider
☐ Other Health Care Professional (Lab, DME, etc)</td></tr>
<tr><td colspan="2">Provider Name (as listed on PRA / EOB):</td></tr>
<tr><td colspan="2">Tax Identification Number:</td></tr>
<tr><td colspan="2">NPI:</td></tr>
<tr><td>Contact Person:</td><td>Phone:</td></tr>
<tr><td colspan="2">E-mail:</td></tr>
<tr><td colspan="2">Please describe your complaint or issue:</td></tr>
<tr><td colspan="2">How can we resolve this issue for you?</td></tr>
</table>

Please include any written documentation that can substantiate your complaint, then send it with your completed complaint form to:

Mail: UnitedHealthcare Community Plan
PO Box 31364
Salt Lake City, UT 84131-0364

Fax: 801-994-1082

Thank you.

ProviderComplaint2022

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United Healthcare® Community Plan