☐ MEMBER ☐ DENTAL PROVIDER ☐ MEDICAL PROVIDER

UnitedHealthcare MEDICARE & RETIREMENT Escalation Request Form

Form Instructions:

1. To escalate a member escalation, your member must have attempted to contact Member Services with noresolution.
2. No part of this form should be filled out by the member because this form is not approved for member use. This form must be filled out on behalf of the member.
3. Complete all applicable fields to ensure timely processing of the request. Missing information will delay escalation of the issue.
4. Save and send the form to your sales leader/upline/supervisor for submission once complete.
5. To ensure the privacy of our members, destroy this form in a secure manner after it has been submitted. Agents who are not UnitedHealthcare employees must send this form via a secure email as it contains PHI.

For All Escalations:

Agent Name:	Agent Writing ID:
Agent Phone:	
Agent Email Address:	

Person Completing Request Form:
Email of Person Completing Request Form:

For Member Escalations (This is member information):

Member Name:		
Medicare ID, if applicable:		
Date of Birth, if applicable:		
Address:		
City:	State:	Zip:
Telephone Number:		
Member Plan:		

Please include any information important to this request.

MA/DUAL/DENTAL **	
Subject Line **	
Description (Enter description of problem and include HPBP #, your name, and agent name) **	
SOT	
Issue Category **	
Provider Type **	
Group Name **	
Street **	
City **	
State **	
Zip Code **	
County **	
PCP Phone # **	
Tax ID # (TIN) (if known)	
MPIN (if known)	
NPI # (if known)	
Provider ID (if known) (needed if for denied claim)	
Member's ID # (needed if for denied claim)	
Date of Service and Provider of Service (needed if for denied claim)	
UCID (if known)	
Product Type (Plan Name)	
Additional Notes on Issue	

**** Required Fields (missing required fields will delay the submission)**