Health Plan of Nevada
A UnitedHealthcare Company

PROVIDER GRIEVANCE FORM

Provider Name: _____ Group Affiliation:_____

If the grievance is regarding a specific member, please include member information:

Member/Insured Name: _____

Member Number: _____ Date of Birth: _____

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

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Signature ***Date***

(If signed, a written response will be submitted to the member/insured)

WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:

COMPANY NAME: Health Plan of Nevada

DEPARTMENT: Provider Services

EMAIL: PROVIDERADVOCATETE@UHC.COM

MAILING ADDRESS: PO Box 14865
Las Vegas, NV 89114-4865

While we encourage grievances to be submitted in writing, you can also contact provider services at (702) 242-7088 (option 2 then 5) to submit your grievance verbally.