UnitedHealthcare Community Plan of Kentucky - External Independent Review (EIR) Request Form

Important note: If you have not yet exhausted an appeal of the adverse decision, then do not submit a request for an EIR. An EIR is an independent review of an adverse appeal decision.

All fields identified with an asterisk are required for the request to be considered complete, including attachments. Incomplete requests will be administratively denied.

Date listed on the Managed Care Organization (MCO) Final Decision Notice*		
MCO appeal reference number listed on notice:*		
Appeal Category*:		
☐ Claim payment determination	☐ Medical Necessity Adverse Benefit Determination	
Party submitting request*:		
☐ Provider	☐ Third-party billing service on behalf of provider	
Name of Billing Service (if applicable):		
Patient information		
Date of service*:	Claim #*:	
Name*:	Date of birth*:	
MCO <enrollee/member> ID number*:		
Provider information		
NPI*:	Tax ID#:	
Address*:		
City*:	State*:	ZIP*:
Name as it appears on W-9*:		

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Provider contact information		
Name*:	Address*:	
City*:	State*:	ZIP*:
Email*:		
Fax number*:	Phone number*:	

Third party billing contact information (completion of this section is required if a third-party biller is submitting this request.)		
Name*:	Address*:	
City*:	State*:	ZIP*:
Email*:		
Fax number*:	Phone number*:	

Attorney contact information (Completion of this section is required if a provider is being represented by an attorney for this request.)		
Name*:	Address*:	
City*:	State*:	ZIP*:
Email*:		
Fax number*:	Phone number*:	

Designated contact for this request (Please check one.)	
☐ Provider	☐ Third-party billing service on behalf of provider

Identify each specific issue and dispute directly related to the adverse final decision issued by the MCO.* Requests containing non-specific statements will not be considered.

State the basis on which the MCO's decision on each issue is believed to be erroneous.* Requests containing non-specific statements will not be considered.

When submitting this form, attach required documentation that supports the External Independent Review request. Incomplete submissions will be rejected.

Number of attached pages:

Attachments must include and are limited to the following: copy of MCO's final adverse decision

Regulatory and Statutory Authority

• 907 KAR 17:035	• KRS 205.646

Please use the below lines for further details if more space is required:

Submit EIR request via email to **EIR_KY@uhc.com** or fax to **844-800-8833.**

MCO comments:

If necessary, requests may also be mailed to:
UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
External Reviews
P.O. Box 31364
Salt Lake City, UT 84131-0364

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