Field Escalation Request Form

1. This form is for enrollment, member, provider and sales escalation issues only. Prior to escalating, **you or the member must have attempted to contact Member Services/PHD to attempt resolution, but the issue was not resolved.**
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 fields** to ensure timely processing of the request. Missing information will delay escalation of the issue. *Required fields below.
4. Save and send the form to your SSC, Sales Director, or SVP.
5. To ensure the privacy of our members, destroy this form in a secure manner after it has been submitted.
6. This form must be emailed using Secure Delivery. UnitedHealthcare employee submitters must use their UnitedHealthcare email address for submission.
7. If you are unable to complete the form electronically, please ensure that all handwritten information is **legible**.

Important Reminder: For Urgent and/or Access to Care escalations, please include **Urgent - Access to Care** in the subject line of the email.

Agent Information:

(Writing Agent information if known)

Agent Name*: _____ **Agent WID or PID*:** _____

Agent Phone: _____ **Agent Email:** _____

Member or Enrollment Escalation Inquiry:

Include name and two of the following are required: date of birth, Medicare number, member number, or complete address

Note: If the member escalation includes a specific provider, please complete the Provider Escalation Inquiry section below.

Member Name*: _____ **Member ID or MBI*:** _____

Member Date of Birth*: _____ **Member Plan*:** _____

Member Phone: _____ **Member Street Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Service (if applicable for claims, provider services, etc.): _____

Date of Initial Attempt to Resolve request via Customer Service*: _____

Provider Escalation Inquiry:

Note: If the provider escalation involves a specific member, please complete the Member/Enrollment Escalation Inquiry section above.

Provider Name*: _____ **Provider Type:** _____

Provider Street Address*: _____

City*: _____ **State*:** _____ **County*:** _____ **Zip Code*:** _____

Provider Phone*: _____ **NPI:** _____ **Plan Name:** _____

Sales Support Escalation Inquiry:

Includes (but is not limited to): Contracting, Commissions, Certifications, System Issues.

Date of Call and Service Request Number for initial attempt to resolve via PHD*: _____

Escalation Description - Please include any information important to this request and description of the issue:

You will be able to expect a response to your initial email within **one business day, and follow up responses, when needed, every other business day.

United Healthcare