Print Form

UHA HEALTH INSURANCE

700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4000
F 866.572.4393
www.uhahealth.com

Provider Claims Action Request

Please use this form to request the reconsideration of a claim. If you are not satisfied, an appeal must be filed within one year of the date that UHA first informed you of the denial or limitation of the claim or coverage for any requested service.

MEMBER INFORMATION

Date of Request: _____

Patient Name (First, Middle, Last)

UHA Member ID #

_____ _____

Date(s) of Service

_____ _____ _____ _____ _____

PROVIDER INFORMATION

Rendering Physician/Provider _____

Provider Group or Company _____

Provider Billing Address _____

If it is determined that money is owed to UHA ☐ Please withhold funds from future payment(s) ☐ We will remit refund to UHA

Contact person for this request _____ _____
Name Phone

CLAIM INFORMATION **Issue(s) to be resolved (please check all that apply)**

UHA Claim Number _____

☐ Denied Claim Line ☐ Incorrect Payment Amount ☐ Coordination of Benefits
☐ Eligibility ☐ Payment Error (Please Describe Below) ☐ Other (Please Describe Below)

Please explain the reason for this request

*** Please note -** Any time Modifier 25 is used, UHA requires Clinical Notes to be reviewed for payment. Any additional medical documentation provided may serve to expedite this request.

Please send completed form and any attachments to:

UHA Customer Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813
Or via Fax: 1-866-572-4393