Medicare Appeal / Grievance Request Form
(This is for *Member* use only)

Member Name: _____ **Member #:** _____

Has this service already been rendered?
☐ Yes ☐ No ☐ This complaint is not regarding a Medical Service

Date(s) of service in question: _____

Facility(s) and/or Doctor(s):_____

Service preformed/Requested: _____

Total amount in dispute: $_____ **Amount Paid by Member (If any): $**_____

Requested outcome of complaint (What would you like to see happen)
☐ Payment of Claim(s) ☐ Approval of denied Service ☐ Reduction of Co-Pay / Co-Insurance to: $_____
☐ Other_____

Please explain your Complaint in detail and provide supporting arguments for your case: (You may attach additional papers as necessary)

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Do you have further supporting evidence to add? (Please include supporting documentation)

_____
_____
_____
_____
_____

Signature:_____ **Date:** _____

Please mail this form to:
Universal Health Care
Attention: Grievances and Appeals Department
PO Box 1964
St. Petersburg, FL 33701-1964

A Medicare Advantage Organization with a Medicare Contract