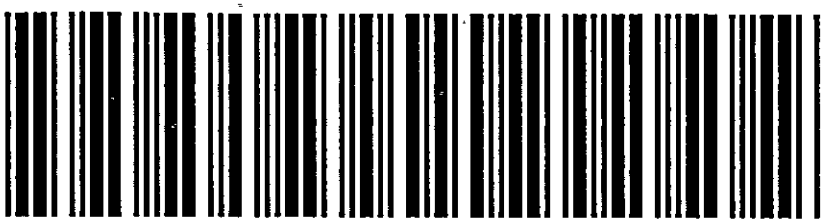

Patch II

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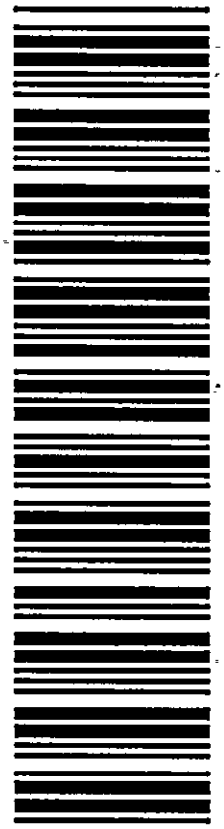
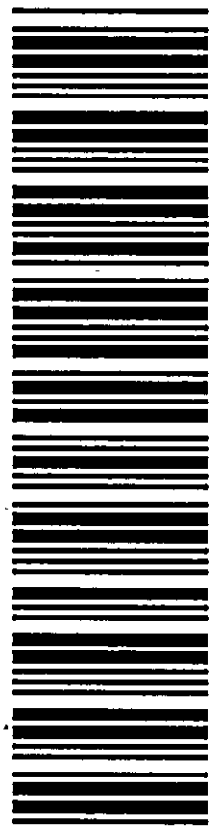


00BREAK00

Document Separator

Used to Separate Each Transaction

00BREAK00



SourceHOV, Inc
4050 South 500 West
Salt Lake City, UT 84123

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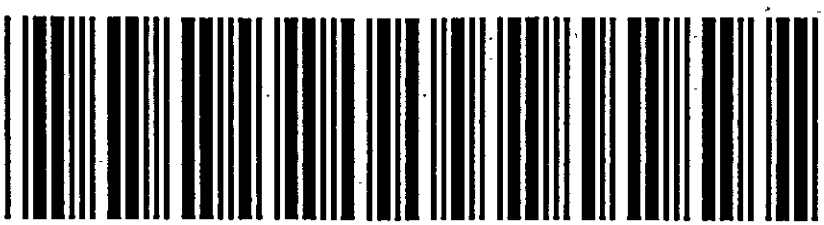


UnitedHealthcare®

A UnitedHealth Group Company

This claim was received in the Appeals P.O. BOX 30432, Salt Lake City, UT, or through fax 801-938-2100

UnitedHealthcare®

Member Service Request Form

Date form completed: 3/17/2021

SECTION I: Your information

Name of person completing this form: Last Dunnewald First David MI A.

Address: 8446 Pierson Court

City: Arvada State: CO ZIP: 80005 Telephone (303) 424-1859 Ext:

What is your relationship to the patient? (Husband and:

☒ Subscriber ☐ Parent/Legal Guardian ☐ Provider of Service ☐ Other** _____

***If "other" is checked, please print and have the patient complete the form titled Authorization For The Use and Disclosure of Information and attach it to your request.*

SECTION II: Information from your explanation of benefits, health statement or ID card

Subscriber ID number (nine-digit number): A 941027060 Group/Contract # (five to seven digits) 0228604

Member (subscriber) name: Last Dunnewald First David MI A.

Patient name: Last Dunnewald First Kathleen MI S.

Patient's date of birth: 09/01/1962

Address: 8446 Pierson Court City Arvada State: Co ZIP: 80005

Date of service: 08/13/2020 Total amount charged: $ 4819.00 (required only if your request is about a claim)

Provider of medical services (as listed on your explanation of benefits or health statement):

SECTION III: Reason for request

☐ I am submitting the additional information requested by UnitedHealthcare. This may include coordination of benefits, full-time student status information, medical records, accident information or other requested information. (Please attach the requested documents along with the letter you received requesting this information, if available.)

☐ I have a question about how a claim was processed, my benefits or available coverage, requirements of my plan, or some other issue. (Please explain below.)

☒ I am requesting a formal review of a decision made by UnitedHealthcare regarding the handling of a claim or coverage for a health service, or I have a complaint regarding a claim, coverage determination or service received. (Please explain below.)

Additional comments: (Required if boxes 2 or 3 are checked above. Attach additional pages if necessary.)
Please do not write on the back of this form. This claim was denied by UHC on 12/11/2020. The provider appealed this decision on 1/7/2021, and we are also now appealing this decision because we have not received a response from UHC. The services of this Assistant Surgeon for my Wife's double mastectomy and breast reconstruction were medically necessary and should not be denied by UHC. Dealing with breast cancer is very difficult, and your denial adds $ costs to our pain!

Thanks,

SECTION IV: Submitting your request

1. Complete this form to the best of your ability. Please do **not** submit new claims to be processed.
2. Attach a copy of your health statement or explanation of benefits, if available, as well as other items that may help us understand your request.
3. Mail this form along with attachments to the PO Box indicated for your group number on the instruction page.

Member Service Request Form Instructions

At UnitedHealthcare, we continuously strive to bring you a higher level of service. Although you are not required to submit this form, completing it will help us address your issue in a timely and thorough manner.

When should I use this form?

You may use this form to submit:

- information requested by UnitedHealthcare
- a question about a claim or your coverage
- a formal review of or a complaint regarding a claim, coverage determination or service received

How do I submit a request?

Please complete the attached form as follows:

Section I: Your information

- Enter the information specific to yourself, as the person completing the form. You may or may not be the person who received medical services. Please remember to also have the patient complete the *Authorization For The Use and Disclosure of Information* form if you are not the patient, enrollee, parent/legal guardian, or provider of service. This form can be obtained from your member website, **myuhc.com®**, under the link "Claims and Accounts." In some circumstances, state law requires that this form be completed if you are not the patient. We will notify you if your submission requires the completion of this Authorization Form.

Section II: Information from your plan's explanation of benefits, health statement or medical ID card

- The items to be completed in this section can be found on your plan's explanation of benefits (EOB) or health statement received from UnitedHealthcare after your claim was processed or from your health plan ID card.
- The subscriber ID is a nine-digit number.
- The group number is a five- to seven-character number.
- Demographic information such as your address cannot be updated by submitting this form. Please contact your employer with any updates to this information.

Section III: Reason for request

- Check the box that best describes your reason for the submission.
- If you are requesting a formal review of a decision made by UnitedHealthcare regarding the handling of a claim or coverage for a health service, please include additional comments to explain your request or situation. You may attach additional pages as necessary. **Please do not write on the back of the form.**

Section IV: Submitting your request

- **Complete and submit only the form that appears on the following page.** Keep this instruction page for your records, as well a copy of the completed form.
- If your request is related to the handling of a claim, attach a copy of your health statement or EOB for each claim, if available. You may obtain a copy of your EOBs on **www.myuhc.com.**
- If you are submitting additional information requested by UnitedHealthcare, please attach a copy of the letter received requesting this information, if available.
- If you have other documentation or items that may help us understand your request or better explain your situation, please attach these items also.
- If your group number, which is listed on your medical ID card, is ***192744, 194422, 196659, 97313, 229050, 393476, 401010, 503777, 700406, 707997, 710639, 714273, 722266, 722267, 722268, 722269, 722270*** **or** ***722271*****, mail the form with any** attachments to: **UnitedHealthcare Member Inquiry/ Appeals**
  PO Box 740816 Atlanta, GA 30374-0816.
- Mail the form with any related attachments to:
  UnitedHealthcare Member Inquiry/Appeals
  PO Box 30432 Salt Lake City, UT 84130-0432.
- Upon receipt of this form and any supporting documentation, we will send you a written response within the time frame required by your state or employer, but no later than 45 days from receipt of necessary information.

UnitedHealthcare®

AA-256ZZ*01*155875-MO-20346-83042-AFUS 41SN

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800

UnitedHealthcare

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

9102108470798

December 11, 2020

DPS$$$PKG
KATHLEEN DUNNEWALD
8446 PIERSON CT
ARVADA CO 80005-5227

Member/Patient Information
Member: DAVID DUNNEWALD
Member ID: A941027060
Patient: KATHLEEN DUNNEWALD
Relationship: SP
Group Name: MOLSON COORS BEVERAGE COMPANY
Group #: 0228604

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$4,819.00	**Amount Billed** *The amount your provider charged for services provided to you.*
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$0.00	**Your Plan Paid** The money your health benefit plan paid.
$4,819.00	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

AA-25622*01*155876-MO-20346-83042-AFUS 42SN

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-877-613-8110

December 11, 2020

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Claim Detail for KATHLEEN DUNNEWALD

Provider: M MILLER **Claim Number:** CJ2050982301 **Patient Account Number:** DUNKA000 222

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
08/13/2020	ASSISTANT SURGERY	KV	$750.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$750.00	$750.00
08/13/2020	ASSISTANT SURGERY	KV	$728.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$728.00	$728.00
08/13/2020	ASSISTANT SURGERY	KV	$1,670.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,670.50	$1,670.50
08/13/2020	ASSISTANT SURGERY	KV	$1,670.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,670.50	$1,670.50
Claim Total:			**$4,819.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$4,819.00**	**$4,819.00**

**This total does not reflect any payments / copays you made at the time of service or purchase. Please wait for a provider bill before making a payment.

Notes*

Please note that appeal deadlines have been extended until further notice due to COVID-19. You should consult with your employer and visit the US Department of Labor website at dol.gov for more information and additional notices about the deadline extensions and how they may apply to you.

KV - THIS PROCEDURE CODE IS NOT ELIGIBLE FOR AN ASSISTANT SURGEON. THEREFORE BENEFITS ARE NOT PAYABLE.

You have the right to receive, upon request and free of charge, a copy of the internal rule, guideline or protocol that we relied upon in making the non-coverage decision for your claim.

Because your family deductible has been satisfied, your remaining individual deductible has been adjusted to $0. The coinsurance period of your plan has begun for all covered members of your family.

Because your family's out-of-pocket maximum has been satisfied, your remaining individual out-of-pocket maximum has been adjusted to $0.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432,

9102108470798

AA-25622*03*155879-MO-20346-83042-AFUS 42SN

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-877-613-8110

December 11, 2020

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2020

KATHLEEN
Relationship: SP

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$3,900.00	$3,041.61	Met
Out of Pocket	$6,850.00	$6,428.64	Met
OUT NET MEDICAL/RX COMBINED			
Deductible	$3,900.00	$3,041.61	Met
Out of Pocket	$14,600.00	$6,428.64	$8,171.36

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$3,900.00	$3,900.00	Met
Out of Pocket	$7,300.00	$7,300.00	Met
OUT NET MEDICAL/RX COMBINED			
Deductible	$3,900.00	$3,900.00	Met
Out of Pocket	$14,600.00	$7,300.00	$7,300.00

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount You Owe: The amount of money you pay for the services you receive.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Year: The time period the benefit maximums apply.

Amount Billed: The amount your provider charged for services provided to you.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

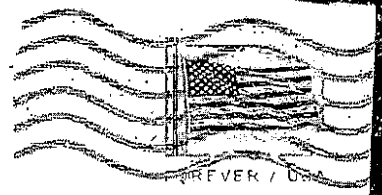
Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Your Plan Paid: The money your health benefit plan paid.

Kathleen Dunnewald
8446 Pierson Ct
Arvada, CO 80005

DENVER CO 802
18 MAR 2021 PM 5 L



United Healthcare Member Appeals
P.O. Box 30432
Salt Lake City, UT
84130-0432

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