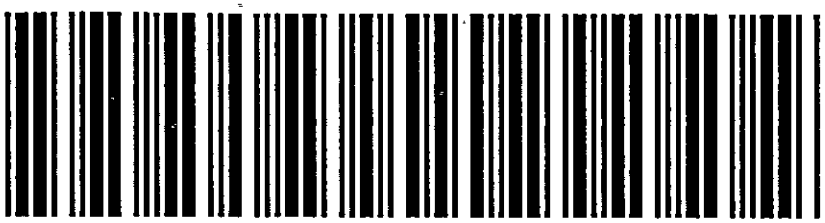
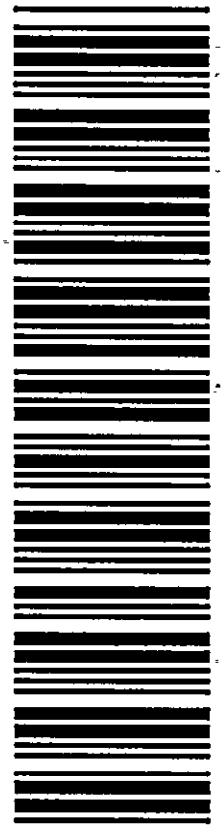


Patch II

9102108371879 BC

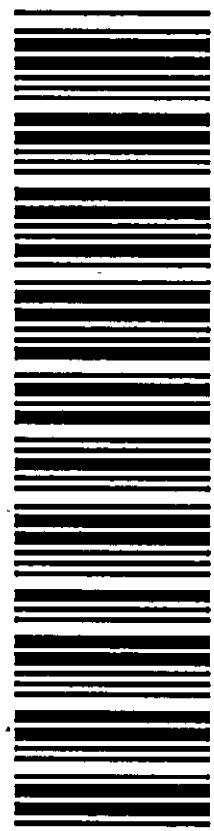


00BREAK00

Document Separator

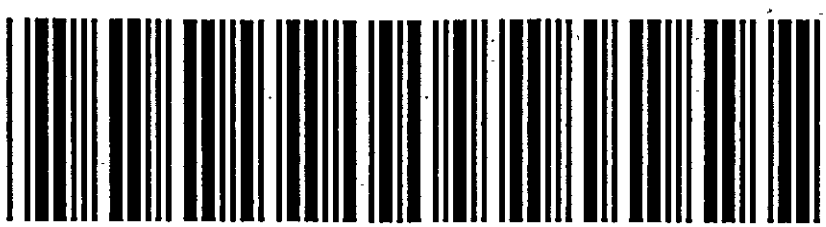
Used to Separate Each Transaction

00BREAK00



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

00BREAK00



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: 03 / 10 / 2021

SECTION I: Your information

Name of person completing this form: Last Zoeller First Deanna MI L

Address: 657 Canyon Trail

City: Lakehills State: Tx ZIP: 78063 Telephone (210) 410-2738 Ext:

What is your relationship to the patient?

☒ 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): 848766963 Group/Contract # (five to seven digits) 701648

Member (subscriber) name: Last Zoeller First Deanna MI L

Patient name: Last Zoeller First Deanna MI L

Patient's date of birth: 09 / 22 / 1971

Address: 657 Canyon Trail City Lakehills State: Tx ZIP: 78063

Date of service: 11 / 20 / 2020 Total amount charged: $ 329.01 (required only if your request is about a claim)

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

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.

Questioning charges for surgery - did not have a surgery. It was only an Office Visit with a vocal cord test. Does not classify as surgery.

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.

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UnitedHealthcare®

JnitedHealthcare Insurance Company
RICHARDSON/SPRGFLD SRVC CNTR
PO BOX 30555
SALT LAKE CITY, UT 84130-0555
Phone: 1-866-873-3902

January 20, 2021

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

Claim Detail for DEANNA ZOELLER

Provider: J BERGERON   Claim Number: CK2791481101   Patient Account Number: OFC305989

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider: Deductible	Copay	Coinsurance	Non-Covered	Amount You Owe**
11/20/2020	OFFICE VISITS	D1	$146.46	$69.53	$76.93	$16.93	$0.00	$60.00	$0.00	$0.00	$60.00
11/20/2020	SURGERY	UG	$430.50	$161.49	$269.01	$0.00	$269.01	$0.00	$0.00	$0.00	$269.01
Claim Total:			$576.96	$231.02	$345.94	$16.93	$269.01	$60.00	$0.00	$0.00	$329.01

**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.

D1 - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. THE AMOUNT YOU OWE MAY INCLUDE YOUR COPAY, COINSURANCE, DEDUCTIBLE, PLUS ANY AMOUNT DUE IF YOU'VE REACHED YOUR BENEFIT LIMIT ON A COVERED SERVICE.

UG - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. YOU HAVE NOT MET YOUR DEDUCTIBLE AND OWE THE AMOUNT SHOWN.

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 30573, Salt Lake City, UT 84130-0573. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review not later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

UnitedHealthcare

UnitedHealthcare Insurance Company
RICHARDSON/SPRGFLD SRVC CNTR
PO BOX 30555
SALT LAKE CITY, UT 84130-0555
Phone: 1-866-873-3902

January 20, 2021

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

Availability of Consumer Assistance/Ombudsman Services:
There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. Your state consumer assistance program may also be able to assist you at:
Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714-9091
Toll-free telephone: 1-800-252-3439
Fax: 1-512-490-1007
Web site: www.texashealthoptions.com
E-mail: ConsumerProtection@tdi.texas.gov

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Disclosure of Provider Status
Not all physicians and providers at contracted facilities (hospital, ambulatory surgical center, etc.) are contracted with your plan. If you receive health care services at or through a contracted facility and the physicians or providers who provided that care are not contracted with your plan, the services may be denied or paid at the non-network level. In those cases, you may be responsible for payment of all or part of the fees for those services. In these situations, the facility or non-contracted physician or provider can choose to bill you for the balance not paid by the health plan for non-covered or out-of-network services. Should you have a complaint regarding payments of health care services, you may contact the Texas Department of Insurance Consumer Protection Division at 1-800-252-3439.

Texas Department of Insurance Notice
You have the right to an adequate network of preferred providers (also known as "network providers").
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

You have the right, in most cases, to obtain estimates in advance:
- from out-of-network providers of what they will charge for their services; and
- from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.myuhc.com or by calling 1-866-873-3902 for assistance in finding available preferred providers.
If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer.
Dates of service prior to 1/1/2020: You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation (if the services were received prior to 1/1/20) by contacting the Texas Department of Insurance at: www.tdi.texas.gov/consumer/cpmmediation.html or by calling 800-252-3439.

6-02-08371-879 BC

SAN ANTONIO TX 780
RIO GRANDE DISTRICT
12 MAR 2021 PM 4 L

USA FOREVER

United Healthcare/Appeals
PO Box 30432
Salt Lake City, UT 84130

84130-043232