



TENNESSEE HEALTH LINK - RECONSIDERATION REQUEST FORM

Instructions: This form is to be completed by a health care professional participating in the UnitedHealthcare Community Plan of Tennessee (UHC) – Tennessee Health Link (THL) program who wants to request an appeal regarding the accuracy of a reported payment or quality metric.

This request form should be submitted in response to a finding in your yearend report. Reconsideration requests must be submitted to UnitedHealthcare Community Plan within 20 business days of when the final performance report is posted at UHCProvider.com. If the reconsideration is not requested within 20 business days, you will waive your ability to pursue reconsideration in any forum. Please submit your completed form to Sarah Howard at sarah_howard@uhc.com.

Please submit completed reconsideration and any required attachments to:

REQUIRED INFORMATION

- Date of Request: _____
THL UHC Contact Name: _____
Organization Name: _____
Tax Identification Number (TIN#): _____
Street Address: _____
City, State, Zip Code: _____
Contact Person: _____
Contact Phone Number: (____) _____
Contact Email Address: _____
Reason for Request: ___Payment Accuracy ___Metrics Accuracy ___Other
Required Attachments:
- Copy of Final Tennessee Health Link Performance Report
Details of Request: