ALLOWABLE REQUEST FORM

Instructions:

Please fill out this form in its entirety. If information is missing, the form will be returned to you.
List all requested codes and modifiers (if applicable) on the second sheet of this form. Once completed, please email this document, in excel format (PDF copies will be returned) to PRI@uhc.com.

Questions? Please reach out to PRI@uhc.com, or call (702) 242-7088, option 2 then option 5.
Please allow 30 days for the request to be completed. Additional time may be needed for large requests.

If your contracted rate is based off of a Medicare fee schedule, you can view that information here
https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules
If your contracted rate is based off of a Medicaid fee schedule, you can view that information here
https://www.medicaid.nv.gov/hcp/provider/Resources/SearchFeeSchedule

Tax ID: ____________

Provider Group Name: ________________________

Specialty: ________________________

Contact Name: ________________________

Contact Email: ________________________

Contact is from which of the following:
(please check one) ☐ **Office** ☐ **Billing Agency** ☐ **Other**

Line of Business
Check all that apply ☐ **HPN** ☐ **SHL/ NNHN** ☐ **SHO** ☐ **UHC HPN MEDICAID**

Please note: Quotes do not guarantee payment. Claim processing is subject to member eligibility, benefits, claim processing guidelines, and contract limitations. For example, for contracts with "lesser of" language, the allowable rate may depend on billed charges. Please review your contract for specifics.