



SIERRA HEALTH AND LIFE  
A UnitedHealthcare Company

### PROVIDER GRIEVANCE FORM

Provider Name: \_\_\_\_\_ Group Affiliation: \_\_\_\_\_

If the grievance is regarding a specific member, please include member information:

Member/Insured Name: \_\_\_\_\_

Member Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

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**Signature**

**Date**

(If signed, a written response will be submitted to the member/insured)

**WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:**

**COMPANY NAME:** Sierra Health & Life  
**DEPARTMENT:** Provider Services  
**EMAIL:** PROVIDERADVOCATE@UHC.COM  
**MAILING ADDRESS:** PO Box 14865  
Las Vegas, NV 89114-4865

While we encourage grievances to be submitted in writing, you can also contact provider services at (702) 242-7088 (option 2 then 5) to submit your grievance verbally.