United Healthcare Community Plan

Appointment assistance request form

P.O. Box 5250
Kingston, NY 12402-5250

First name: _____ Last name: _____

Member ID #: _____

Best phone number to reach you: _____

Your email address: _____

What type of provider or specialist do you need?
If you want an appointment with a specific provider, please give their first and last name.

_____

_____

Please provide your location (the address where you are currently living):

_____

_____

Do you need help arranging transportation for health care visits? ..... ◯ Yes ◯ No

Have you already contacted us to ask for help making an appointment? ..... ◯ Yes ◯ No

If yes, please give the date you contacted Member Services. Date: _____ / _____ / _____
(DD/MM/YY)

You can make a formal complaint (this is also called "filing a grievance")
If you want to file a grievance, check the box to the right. ..... ☐ I want to file a grievance

Submit

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