

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

UnitedHealthcare

[Claims Department Address]
[City, State, Zip Code]

Subject: Dispute of Payment for Claim #[Claim Number]

Dear Claims Department,

I am writing to formally dispute the payment decision regarding my recent claim (Claim #[Claim Number]) dated [Date of Service]. After reviewing the explanation of benefits, I believe that the denial/partial payment of this claim is incorrect.

[Briefly explain the nature of the service provided and any relevant details that support your position. Include dates, provider information, and any policy details that may be applicable.]

Attached to this letter, you will find the necessary documentation including [list any documents you are including, such as invoices, medical records, etc.]. I kindly request a thorough review of my case and a reconsideration of the payment amount.

Thank you for your prompt attention to this matter. I look forward to your response and resolution of this dispute.

Sincerely,

[Your Name]
[Your Policy Number]