## 2024 HPN Provider Summary Guide

## Health Plan of Nevada A UnitedHealthcare Company

## Health Plan of Nevada Complaint Form

| wember/insured Name  | e:                         |   |  |
|--|----------------------------|---|--|
| 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): |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
|  |                            |   |  |
| Signature  |                            | Date  |  |
| (If signed, a written resp   | ponse will be s            | ubmitted to the member/insured)                                 |  |
| WHEN COMPLETED, THIS   | FORM SHOULD                | BE SUBMITTED TO:  |  |
| COMPANY NAME:  | Health Plar                | n of Nevada   |  |
| DEPARTMENT:  | Customer F                 | Customer Response and Resolution Department                     |  |
| MAILING ADDRESS:   | P.O. Box 1-<br>Las Vegas,  | 4865<br>NV 89114-4865   |  |
| As always, the Member numbers:   | <sup>.</sup> Services Depa | artment can be contacted directly by telephone at the following |  |
| HEALTH PLAN OF NEVAD   | A:                         | (800) 777-1840  |  |
| MEDICAID AND NEVADA CHECK UP   |                            | (800) 962-8074  |  |
| TTY  |                            | 711   |  |