Group Claim Office
P.O. Box 80139
Baton Rouge, LA 70898-0139
Phone: (888) 400-9304 or (225) 400-9304
www.unum.com

REQUEST FOR REVIEW/GRIEVANCE FORM

Return completed form via fax **(855) 400-9307**, email **DentalClaims@Unum.com** or **VisionClaims@Unum.com**, or mail to the address above.

Patient Information

Patient Name (Last name, First name, MI):	Patient's social security number:		Patient's birth date _____ / _____ / _____ MM DD YY
Patient's address:	City:	State:	Zip code:
Name of individual making this request:	Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____		
Social security number of individual making the request:	Daytime telephone: (_____) _____		

Please summarize your grievance and include the claim number shown on your Explanation of Benefits. Attach additional sheets as necessary. If possible, also attach a copy of any documents that relate to your grievance. _____

_____

_____

_____

Authorization for Release of Medical Records to Unum

I authorize the release of my health or medical information and medical records regarding this request to Unum for the purpose of conducting a review, limited as follows:

☐ No limitations

☐ Release only records for the time period of _____ to _____.

☐ Do not release the following information (dates of treatment, diagnosis, physician's name): _____

_____

Signature of patient or representative: _____ **Date:** _____

Authorization of representative (if applicable)

I authorize _____ to represent me in this grievance and all related matters. I authorize the disclosure of my health information to my representative by Unum during the process of Unum's review of this grievance.

Authorized representative's daytime phone number: (_____) _____	Authorized representative's email address:		
Authorized representative's address:	City:	State:	Zip code:

Signature

Signature of patient or guardian: _____ **Relationship to patient:** _____ **Date:** _____