Cardholder Dispute Form

Please complete this form if you are disputing a charge to your UnitedHealthcare Health Care Spending Card MasterCard®. Print this form, sign it, and attach all supporting documents. Then mail or fax all of the information to the address or fax below. Please make sure to sign and date your form.

Part 1: UnitedHealthcare Contact Information

Mail
UnitedHealthcare
P.O. Box 7235
Sioux Falls, SD 57117-7235

Fax
1-954-377-0072

Questions
Call 1-866-755-2648

UnitedHealthcare will send you a letter confirming the form has been received.

Part 2: Cardholder Information (Please print, type, or write clearly)

Name of policyholder (Last) (First) (MI)	
Card number (XXXX XXXX XXXX)	Member ID number (found on your health plan ID card)
Mailing address (Street) (City) (State) (ZIP code)	
Telephone number (Home) (Work)	

Part 3: Description of Dispute

Merchant name	Transaction date	Transaction amount	Amount in dispute

Details of transaction activity (if necessary, please use an additional sheet)

Please check only one reason (box) that applies

☐ 1. I certify that the charge listed on the account history was not made by me or a person authorized by me to use my card. I did not receive any goods or services from this transaction nor did any person authorized by me.

☐ 2. Although I did engage in a transaction with the above merchant, I have no knowledge of the particular transaction noted above. This transaction was not authorized by me or anyone representing me. My cards were in my possession at the time of the above transaction.

☐ 3. Although I did engage in the above transaction (complete ONE of the following statements and provide as much detail as possible to support your statement):

a. The dollar amount of the sale was increased from $_____ to $_____. I am enclosing a copy of my sales receipt, which reflects the correct dollar amount.

b. I dispute $_____, which is (check one) ☐ the entire charge shown on my statement, or ☐ a portion of the $_____ charge shown on my statement. I have contacted the merchant, and a credit has NOT been applied to my account. (Please provide details of the circumstances surrounding this transaction and your calculations used to derive the correct amount, if amount is less than the total billed to your account.)

c. I have never received the merchandise. I expected to receive it during the week of (date) _____. I have since contacted the merchant and asked that a credit be applied to my account.

d. All or part of the shipped or delivered merchandise was defective or damaged when received. I returned the merchandise on (date) _____, but have not received a credit for the amount of $_____. I am enclosing a detailed statement describing the defects of the merchandise and am enclosing a copy of my proof of return list of the merchandise received, the items returned, and the cost of each item.

e. The above transaction is a duplication of an authorized transaction that took place on (posting date) _____. The merchant was not able or willing to provide the (describe the requested merchandise/services) _____. I am enclosing a detailed explanation of the reason(s) why. I am also providing details of my attempts to resolve this matter with the merchant, including date(s) and the merchant's response(s).

☐ 4. I received a credit slip, but it was applied to my account as a charge. I am enclosing a copy of this credit slip.

☐ 5. I received a credit slip, but it has not yet been applied to my account. I am enclosing a copy of this credit slip.

☐ 6. Other:

Signature of policyholder	Date

UnitedHealthcare®

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