Optum

Provider dispute resolution request

Note: Submission of this form constitutes agreement not to bill the patient.

Instructions

Submit your claim reconsiderations online
Contracted providers who need to submit a claim reconsideration request should use the **Optum Pro portal**. By submitting your request on the portal, you can view the request status and completion date, and upload supporting documentation.

If your supporting documentation exceeds 12 MB or you're an out-of-network provider, follow the instructions below for submitting your request by secure email or mail.

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the description of your reconsideration request.
- Provide additional information to support the description of the reconsideration request. You do not need to resubmit the original claim.

Mail: You can mail the completed form to:

Provider Dispute Resolution
P.O. Box 30539
Salt Lake City, UT 84130

NOTE: This form is for reconsiderations only. To submit a formal appeal, please see the instructions listed on the back of your Explanation of Payment (EOP).

*Provider name:	*Provider TIN:
Provider address:	

Provider type:

☐ MD ☐ Mental health professional ☐ Mental health institutional
☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance
☐ Other _____ (Please specify type of "other.")

Claim information: ☐ Single ☐ Multiple "like" claims **(attach spreadsheet)** Number of claims:

*Patient name:	*Date of birth (MM/DD/YYYY):
*Member's health plan ID:	*Patient account number:
*Service from date (MM/DD/YYYY):	*Service to date (MM/DD/YYYY):
Claim ID number:	(If multiple claims, use attached spreadsheet.)

Please check the description that best fits: ☐ Claims ☐ Authorizations ☐ Contract issues ☐ Medical records

Description of dispute:

*Contact name: _____ *Telephone number: _____-_____-_____ Ext._____

*Signature: _____ *Fax number :_____-_____-_____
(Hard copy only)

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Provider dispute resolution request (For use with multiple "like" claims.)

	*Patient name		*Date of birth	*Health plan ID number	Claim ID number	*Service from/to date	Claim amount billed	Claim amount paid	Expected reimbursement amount	Comments
	Last	First								
1	Last	First								
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

☐ **Check here if additional information is attached.**

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