Provider Claim Reconsideration 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 (111-111-1111): _____Ext._____ **(if applicable)**

*Signature: _____ *Fax Number (111-111-1111): _____
(Hard Copy Only)

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Provider claim reconsideration 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										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
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15										

☐ Check here if additional information is attached

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