Optum

Provider Claim Reconsideration Request

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

INSTRUCTIONS

- 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 30788
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: _____ (Hard Copy Only) *Fax Number (111-111-1111): _____

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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										
13										
14										
15										

☐ Check here if additional information is attached

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