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 7 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.

Secure email: If you have a secure email system, please submit reconsideration requests to **claimdispute@optum.com**

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)

Optum

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

Page _____ of _____