



# 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](mailto: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:	<input type="checkbox"/> MD	<input type="checkbox"/> Mental Health Professional	<input type="checkbox"/> Mental Health Institutional	
	<input type="checkbox"/> Hospital	<input type="checkbox"/> ASC	<input type="checkbox"/> SNF	<input type="checkbox"/> DME <input type="checkbox"/> Rehab
	<input type="checkbox"/> Home Health	<input type="checkbox"/> Ambulance		
	<input type="checkbox"/> 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: <input type="checkbox"/> Claims <input type="checkbox"/> Authorizations <input type="checkbox"/> Contract Issues <input type="checkbox"/> Medical Records	
Description of dispute:	
*Contact Name: _____	*Telephone Number (111-111-1111): _____ Ext. _____ <small>(if applicable)</small>
*Signature: _____	*Fax Number (111-111-1111): _____
<b>(Hard Copy Only)</b>	



## 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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