



## 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.

#### 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 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:	<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. _____ (if applicable)
*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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