Optum

Provider Dispute Resolution 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 DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. It is not necessary to resubmit the original claim.

Mail the completed form to: **Provider Dispute Resolution**
PO Box 2500
Rancho Cucamonga, CA 91729-2500

Description of Dispute:
Expected Outcome:

*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 (page 2) Number of claims: _____
*Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.

*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):
Original Claim ID Number:	(If multiple claims, use page 2)

Please check the description that best fits: ☐ Claims ☐ Authorizations ☐ Contract Issues

Dispute Type:
☐ Seeking Resolution Of A Billing Determination
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Underpayment/Overpayment
☐ Other _____ (please specify type of "other")

Contact Name: _____ Telephone Number (111-111-1111): _____
Signature: _____ Fax Number (111-111-1111): _____
(Hard Copy Only)

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

	* Patient Name		Date of Birth	*Health Plan ID Number	Original Claim ID Number	*Service From/ To Date	Original Claim Amount Billed	Original Claim Amount Paid
	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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