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.
- Provide additional information to support the description of the dispute. It is not necessary to resubmit the original claim.

You now have several options for submitting your requests for reconsideration to Optum:

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

Or mail the completed form to: **Provider Dispute Resolution**
**PO Box 30539**
**Salt Lake City, UT 84130**

**NOTE:** This form is for claim disputes and 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)**

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# PROVIDER DISPUTE RESOLUTION 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 | | | | | | | | |
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| 15 | | | | | | | | | | |

☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

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