AdvantagePlus
Network–Connecticut
A partnership of Optum® and Hartford HealthCare

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.

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 30781
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).

*To request access to the Optum Pro portal, contact the Advantage Plus Network team via email: **APNCTNetwork@optum.com**.

*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)