

**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](mailto:claimdispute@optum.com).

If you do not have a secure email in place, please contact our service center at [1-877-370-2845](tel:1-877-370-2845). We will ask for your email address and will send a secure email for claim reconsideration requests.

You can fax your requests to [1-888-905-9495](tel:1-888-905-9495).

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:	<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: _____ (Hard Copy Only)	*Fax Number (111-111-1111): _____



# 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								
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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