

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 do not have a secure email in place, please contact our service center at **1-888-556-7048**. We will ask for your email address and will send a secure email for claim reconsideration requests.

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:	<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): _____
(Hard Copy Only)	