OPTUM™
Medical Network

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 your own secure system, please submit reconsideration requests to: claimdispute@optum.com.

If you do not have a secure email in place, please contact our service center at 1-877-370-2845. We will ask for your email address and will send a secure email for claim reconsideration requests to be sent to our office.

You can fax your requests to 1-888-905-9495.

Or mail the completed form to: **Provider Dispute Resolution OMN**
PO Box 46770
Las Vegas, NV 89114-6770

*Provider Name:	*Provider TIN:
Provider Address:	

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):

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

Description of dispute:

Contact Name: _____ Telephone Number (111-111-1111): _____

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