Optum

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										
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7										
8										
9										
10										
11										
12										
13										
14										
15										

☐ **Check here if additional information is attached**

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