Advantage Plus
Network–Connecticut
A partnership of Optum® and Hartford HealthCare

Provider Claim Reconsideration Request

Note: Submission of this form constitutes agreement not to bill the patient

INSTRUCTIONS

Submit your claim reconsiderations online
Contracted providers who need to submit a claim reconsideration request should use the **Optum Pro portal**. By submitting your request on the portal, you can view the request status and completion date, and upload supporting documentation.

If your supporting documentation exceeds 7 MB **or** you're an out-of-network provider, follow the instructions below for submitting your request by secure email or mail.

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the description of your reconsideration request
- Provide additional information to support the description of the reconsideration request. You do not need to resubmit the original claim.

Secure email: If you have a secure email system, please submit reconsideration requests to **claimdispute@optum.com.**
Mail: You can mail the completed form to:

Provider Dispute Resolution
PO Box 30781
Salt Lake City, UT 84130

Note: This form is for 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: ☐ 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: ____________ (Hard Copy Only)	*Fax Number (111-111-1111): ____________

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PROVIDER CLAIM RECONSIDERATION 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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