UnitedHealthcare Claim Reconsideration Request Form

Instructions: This form is to be completed by UnitedHealthcare – contracted physicians, hospitals or other health care professionals to request a claim reconsideration for members enrolled in commercial benefit plans administered by UnitedHealthcare and Medicare plans administered by SecureHorizons® and Evercare®.
Mail address: Send all Claim Reconsideration requests to the address on the back of the members identification card (ID), or the address on the EOB or PRA. NOTE: If you are receiving the consolidated 835, you may verify the enrollee's correspondence address using the eligibility search function on UnitedHealthcareOnline.com.

☐ Physician ☐ Hospital ☐ Other health care professional (Lab, Durable Medical Equipment (DME), etc) Date form completed:_____

No new claims should be submitted with this form. Please submit a separate form for each claim.

Member information

Member ID:	Control / Claim #:	Date of Service:	Billed Amount:
Member Name: Last		First	MI
Street Address		State	Zip
Patient Name: Last		First	MI

Physician/health care professional information

Tax Identification Number (TIN):	Phone Number: ( )	Email address:

Physician Name (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):

Last	First	MI
Street Address	State	Zip
Facility/Group Name	Contact Person:	

Option amount owed:

Reason for request

☐ 1. Previously denied / closed as "Exceeds Filing Time" *What should I submit as evidence of timely filing?*
Electronic claims – include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
Paper claims – include a copy of a screen print from your accounting software to show the date you submitted the claim.
The accounting software information must also include proof that the claim is for the correct patient and the correct visit.
• Proof of timely filing could also include other insurance carrier's denial/rejection, EOB, letter indicating terminated coverage, not a plan participant, etc.

☐ 2. Previously denied / closed for "Additional Information" *(provide description and/or requested documents)*

☐ 3. Previously denied / closed for "Coordination of Benefits" information *(attach primary carrier's EOB)*

☐ 4. Resubmission of a corrected claim *(explain correction below)*

☐ 5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment *(explain below)*

☐ 6. Resubmission of "Prior Notification Information" *(including notification information)*

☐ 7. Resubmission of "Bundled claim" *(including all supporting information)*

☐ 8. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare to close UnitedHealthcare's portion of this claim in your practice management system, including dollar amount if possible.

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a letter of appeal and receipt of a response from UnitedHealthcare. To submit a formal appeal, submit a letter outlining your dispute, any supporting documentation, including our response to the reconsideration request, and the date your reconsideration stage was completed to:

UnitedHealthcare Provider Appeals P.O. Box 30559 Salt Lake City, UT 84130-0559

Required attachments:

• Copy of PRA or EOB • Claim form (with corrections if necessary) • Other required attachments as listed above.

You may have additional rights under state law. For review of claims for members enrolled in other benefit plans, please refer to one or more of the following for information on requesting claim reviews: the website for the entity listed on the member's health care ID card, the EOB for the applicable claim or UnitedHealthcareOnline.com. You may also call the telephone number on the member's health care ID card for information on how to request claims reviews.