UnitedHealthcare Single Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals to request a claim reconsideration for members enrolled in benefit plans administered by UnitedHealthcare.
NOTE: Please submit a separate claim reconsideration request form for each claim reconsideration request

No new claims should be submitted with this form. Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.

Please refer to the Claim Reconsideration cover sheet or your provider administrative manual for additional details including where to send Claim Reconsideration requests. You may verify the member's address using the eligibility search function on the website listed on the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other health care professional (Lab, Durable Medical Equipment (DME),etc)

Member information **Date form completed:**

Member ID:	Control / Claim #:	Date of Service:	Billed Amount:
Member Last Name		First Name	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 or other health care professional (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):

Last Name First MI

Street Address State Zip

Facility/Group Name Contact Person:

Option amount owed:

Reason for request: ***(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration definition sheet located on our website)***

☐ 1. Previously denied / closed as "Exceeds Filing Time"
☐ 2. Previously denied / closed for "Additional Information"
☐ 3. Previously denied / closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed but rate applied incorrectly resulting in over/underpayment
☐ 6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of "Bundled claim"
☐ 8. Other *(explain below)*

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

Comments:

Required attachments:

- Copy of PRA or EOB • Claim Form is **ONLY** required for Corrected Claims Submissions • Other required attachments as listed above

You may have additional rights under individual state laws. 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 or the EOB for the applicable claim. You may also call the telephone number on the member's health care ID card for information on how to request claims reviews.