OptumCare
P.O Box 30539
Salt Lake City, UT 84130

Contracted provider appeal form for medical necessity

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing **description of appeal** and **expected outcome.**
- Provide additional information to support the description of the appeal. Do not include a copy of a claim that was previously processed. Explain the basis for appeal of decision based on current applicable CMS and/or Milliman Care guidelines.

Mail the completed form to the following address, which is specific to OptumCare® appeals.
OptumCare provider appeal unit
P.O Box 30539, Salt Lake City, UT 84130
Service phone: 1-877-370-2845
For provider appeal inquiries or filing information, contact us at the telephone number listed above.

***Provider name:**	***Provider tax ID #:**
Provider address:	**Contracting:** ☐ **Yes** ☐ **No**

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME
☐ Rehab ☐ Home health ☐ Ambulance ☐ Other: _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims: _____

***Member name:**	**Date of birth:**
***Original claim ID number:** (If multiple claims, use attached spreadsheet)	
***Service "from/to" date:**	**Original claim amount billed:** / **Original claim amount paid:**

Appeal type: ☐ Appeal of medical necessity/utilization management decision ☐ Non-covered services ☐ Denied services
☐ Disputing a request for reimbursement of overpayment ☐ Other: _____

***Description of appeal: Indicate reason for appeal, provider's position and basis**
(Additional paper can be attached if necessary)

***Expected outcome: Please provide by claim, if multiple**
(Additional paper can be attached if necessary)

_____ **Contact name (please print)**
_____ **Title**
_____ **Telephone # (w/area code)**
_____ **Signature and date**
_____ **Email address**
_____ **Fax # (w/area code)**

☐ ***Check here if additional information is attached.***
(Please do not staple information)

Page ____ **of** ____

For health use only
Case # _____
Provider # _____

Contracted provider appeal form for medical necessity

Instructions (for use with multiple "like" claims only):

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing **description of appeal** and **expected outcome.**
- Provide additional information to support the description of the appeal. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Provider Inquiry Request form instead of the Provider Appeal Resolution form.

Mail the completed form to the following address, which is specific to OptumCare appeals.

OptumCare provider appeal unit
P.O Box 30539, Salt Lake City, UT 84130
Service phone: 1-877-370-2845

For provider dispute inquiries or filing information, contact us at the telephone number listed above.

Number	*Patient name		Date of birth	*Original claim ID number	*Service from/to date	Original Claim Amount Billed	Original claim amount paid	*Expected outcome
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

☐ ***Check here if additional information is attached.***
(Please do not staple information)

Page ____ of ____

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