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 | | | | | | | | |
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☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

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