UnitedHealthcare Request for Reconsideration Form

Mail form to the address on the Explanation of Benefits (EOB) or the Provider Remittance Advice (PRA).

☐ **PHYSICIAN** ☐ **HOSPITAL** ☐ **Other health care professional (Lab, DME, etc)**

Date Form Completed: _____

☐ **First Submission of Request for Reconsideration** ☐ **Subsequent Submission of Request for Reconsideration**

ENROLLEE INFORMATION

☐ Commercial Enrollee ☐ Medicare Enrollee ☐ Medicaid Enrollee

Enrollee ID: _____

Enrollee Name: Last _____ First _____ MI _____

Patient Name: Last _____ First _____ MI _____

Control / Claim #: _____ D.O.S. _____ Billed Amount _____

PHYSICIAN/HEALTH CARE PROFESSIONAL INFORMATION

Tax Identification Number: _____

Physician Name (as listed on PRA / EOB): Last_____ First_____ MI_____

and / or Facility/GroupName _____

Contact Person:_____ Phone Number:_____

REASON FOR RECONSIDERATION

☐ 1. Previously denied / closed as "Exceeds Filing Time" *(attach valid proof of timely filing, computer generated activity or print screen, EOB statement or letter from another insurance carrier which proves claims were filed timely)*

☐ 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 Explanation of Benefits)*

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

Comments: _____

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Required Attachments:
- Copy of Provider Remittance Advice (PRA) or EOB
- Only send HCFA if a corrected claim
- Other required attachments as listed above.

FAX NUMBERS
Salt Lake City fax: 801-567-5499
Atlanta fax: 801-567-5498
San Antonio fax: 801-567-5497

NO NEW CLAIMS SHOULD BE SUBMITTED WITH THIS FORM.
SUBMIT A SEPARATE FORM FOR EACH CLAIM