Advantage Plus
Network–Connecticut
A partnership of Optum® and Hartford HealthCare

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE.
- Provide additional information to support the description of the dispute. It is not necessary to resubmit the original claim.

If you do not have a secure email in place, please contact our service center at **1-888-556-7048.**
We will ask for your email address and will send a secure email for claim reconsideration requests.

Or mail the completed form to: **Provider Dispute Resolution**
PO Box 30539
Salt Lake City, UT 84130

NOTE: This form is for claim disputes and reconsiderations only. To submit a formal appeal, please see the instructions listed on the back of your explanation of payment (EOP).

*To request access to the Optum Pro Portal, contact the Advantage Plus Network team via email:
APNCTNetwork@optum.com

*Provider Name:	*Provider TIN:
Provider Address:	
Provider Type: ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")	

CLAIM INFORMATION ☐ Single ☐ Multiple "LIKE" Claims **(attach spreadsheet)** Number of claims: _____

*Patient Name:	*Date of Birth (MM/DD/YYYY):
*Member's Health Plan ID:	*Patient Account Number:
*Service From Date (MM/DD/YYYY):	*Service To Date (MM/DD/YYYY):
*Claim ID Number:	(If multiple claims, use attached spreadsheet)

Please check the description that best fits: ☐ Claims ☐ Authorizations ☐ Contract Issues ☐ Medical Records
Description of dispute:
*Contact Name: _____ *Telephone Number (111-111-1111): _____Ext._____ (if applicable) *Signature: _____ *Fax Number (111-111-1111): _____ (Hard Copy Only)

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