Claims Reconsideration Request Form

UnitedHealthcare Community Plan

To request reconsideration of a claim, please complete and mail this form along with a copy of the related provider remittance advice or explanation of benefits to the following address. Please submit a separate form for each claim reconsideration request.

You may also submit claim reconsideration requests at UHCprovider.com > Link > Claims Reconsideration. Simply sign in to Link with your Optum ID. If you don't have an Optum ID, select New User to register.

If you have questions, please contact your Provider Advocate or Provider Services at 800-445-1638 or 800-293-3740 for Long Term Care. Thank you.

UnitedHealthcare Community Plan
PO Box 5290
Kingston, NY 12402-5290

Member Information

Member ID Number	Control/Claim Number	Date of Service	Billed Amount
Member Last Name		First Name	MI
Street Address		State	ZIP
Patient Last Name (if different than member)		First Name	MI

Care Provider Information

Tax Identification Number		Phone Number	
Email Address			
Care Provider Last Name		First	MI
Street Address	City	State	Zip
Facility/Group Name		Contact Person	
Contact Person's Fax Number			

Reason for Request

- ☐ 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 resulted in overpayment/underpayment
- ☐ 6. Resubmission of "Prior Notification Information"
- ☐ 7. Resubmission of a claim with "Bundled" services
- ☐ 8. Other (explain in the following box)

In the following box, please tell us what you request from UnitedHealthcare Community Plan to close this out in your practice management system, including dollar amount if possible. Thank you.

Date form completed_____

You may have additional rights under state laws. Please review the provider administrative guide or your agreement if you need more information