## Single Claim Reconsideration/Corrected Claim Request form

This form is to be completed by physicians, hospitals or other health care professionals for claim reconsideration requests for our members.

NOTE

- **Please submit a separate form for each claim**
- **No new claims should be submitted with this form**
- **Do not use this form for formal appeals or disputes. Continue to use your standard process**

Please refer to the preceding guide for instructions and where to mail this form. You may want to verify the member's information using the website listed on the back of the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other health care professional (lab, durable medical equipment (DME), etc.)

### Member information

**Date form completed** ______________________

| **Member ID** | Control / Claim # | Date of service | Billed amount |
|---|---|---|---|
| **Member** last name | | First name | MI |
| Street address | | State | ZIP code |
| **Patient** Last name | | First name | MI |

### Physician/health care professional information

Tax identification number (TIN): ____________________ Phone number (with area code): ____________________

Email address: ____________________

Physician or other health care professional name (as listed on provider remittance advice (PRA)/explanation of benefits (EOB)

Last name ____________________ First ____________________ MI ____

Street address ____________________ City ____________________ State ____ ZIP code ____

Facility/group name ____________________ Contact person ____________________

Expected amount owed ____________________ Contact fax number (with area code) ____________________

### Reason for request: *(Information about the reasons and required documentation can be found on the Claim Reconsideration/Corrected Claim Quick Reference Guide)*

☐ 1. Previously denied or closed as "Exceeds Filing Time"
☐ 2. Previously denied or closed for "Additional Information"
☐ *3.* Previously denied or closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed, but rate applied incorrectly resulting in overpayment/underpayment (Network Providers – check your fee schedules)
☐ 6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of a claim with "Bundled" services
☐ 8. Other *(explain below)*

**Please include what you expect from UnitedHealthcare to close this claim in your practice management system, including dollar amount if possible:**

| **Comments** |
|---|
| |

**Required attachments**

- Copy of PRA or EOB
- A CMS-1500 or UB-04 claim form is **ONLY** required for corrected claim submissions
- Other required attachments as listed in the guide

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

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