Optum

Quick Reference Guide

Reconsideration and appeal process

Optum Behavioral Health Solutions network providers will follow a 2-step process to disagree with the outcome of a Commercial or Medicare Advantage clinical prior authorization request or claim processing decision. With the 2-step process, providers should request reconsideration review of a Commercial or Medicare Advantage claim before filing an appeal.

Deadline: The 2-step process allows for a total of 12 months for submission for both steps (Step 1: Reconsideration and Step 2: Appeals). If a different deadline is required by state law or outlined in your Participation Agreement, that timeline supersedes the 12 months noted.

Required documentation: Include member-specific treatment plans, clinical records, payment appendices or other items that support why you believe our decision was incorrect. **Proof of claim timely filing:** Include confirmation we received and accepted your claim within your timely filing limit. Refer to your Participation Agreement for your specific timely filing requirements.

Step 1: Request reconsideration

Complete this step if you disagree with the outcome of a prior authorization request or a processed claim decision.

Complete a reconsideration request form (available on providerexpress.com > Admin Resources > Forms).

By mail

Optum Behavioral Health Solutions
P.O. Box 30757 • Salt Lake City, UT 84123

Step 2 (if needed): Submit an appeal

Complete this step if you disagree with the outcome of the claim reconsideration in Step 1.

Submit a written request indicating the factual or legal basis for appeal, along with any additional records or documentation you want us to review.

Online

Using the Provider Express secure portal:

- Go to providerexpress.com > Log In > Sign in with your One Healthcare ID and password
- Appeals (top right corner) > Appeals Summary & Submission > select Submit Claim Appeal or Submit Clinical Appeal

By fax

1-855-312-1470

Decision: Once each review is complete, you'll be notified in writing of the outcome.

- **Overturned claim decisions:** If the claim requires an additional payment, the Provider Remittance Advice (PRA) will serve as notification of the review outcome.
- **Upheld decisions:** If the original prior authorization denial or claim decision is upheld, you'll be sent a letter outlining the details of the review.

More information: Review full details on the 2-step reconsideration and appeal process in the National Provider Manual.

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