Optum

Behavioral Health Reconsideration Request Form

This form is to be completed by a Behavioral Health provider for reconsideration requests of a prior authorization denial or claim processing decision. The reconsideration review process is only available for Commercial and Medicare Advantage claims and may not apply in all states. See the National Network Manual for more information. Please refer to the following pages for instructions and how to submit this form. You may want to verify the member's information using the Provider Express secure portal. To do so, go to providerexpress.com and click Log In.

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**

Required attachments:
- Copy of PRA or EOB
- Other required attachments as indicated in on the following pages

☐ Provider ☐ Facility

Member information	**Date form completed**		
Member ID	**Control/Claim #**	**Date of service**	**Billed amount**
Member last name	**Member first name**	**Member middle initial**	
Street address	**State**	**ZIP code**	
Patient last name	**Patient first name**	**Patient middle initial**	

Provider information

Tax Identification Number (TIN): _____ Phone number (with area code): _____

Email address: _____

Provider name (as listed on provider remittance advice (PRA)/explanation of benefits (EOB):

Last name: _____ First: _____ Middle initial: _____

_____

Street address City State ZIP code

Facility/group name: _____ Contact name: _____

Expected amount owed: _____ Contact fax number (with area code): _____

Reason for request:

☐ **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.** Previously processed, but rate applied incorrectly resulting in overpayment/underpayment (network providers, check your fee schedules)
☐ **5.** Resubmission of "Prior Notification Information"
☐ **6.** Resubmission of a claim with "Bundled" services
☐ **7.** Requesting Clinical Reconsideration
☐ **8.** Other (explain below)

Please include what you expect from Optum to resolve this claim, including dollar amount if possible:

Comments

You may have additional rights under individual state laws. Please review your Participation Agreement for more information.

Behavioral Health Reconsideration Request Instructions

Overview

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.* Providers should request reconsideration before filing an appeal of a prior authorization or claims decision. This process applies for prior authorization requests or claim submissions that are denied or paid at a reduced rate due to a lack of prior authorization or lack of medical necessity.

Submission Options

By mail

Prior Authorizations:
Optum Behavioral Health Solutions
P.O. Box 30512
Salt Lake City, UT 84130-0512

Processed Claims:
Optum Behavioral Health Solutions
P.O. Box 30757
Salt Lake City, UT 84123

By fax

Send via secure fax to:
1-855-312-1470

Reason for Reconsideration Request

On the form, you will select 1 of 8 reasons for the request:

1. **Denied as exceeds timely filing –** Timely filing is the time limit for filing claims, which is specified in the network contract, a state mandate or a benefit plan. For an out-of-network provider, the benefit plan decides the timely filing limits. These requests require one of the following attachments:
   - **Requirements for electronic claims:** Submit an electronic data interchange (EDI) acceptance report (not a submission report). This must show that Optum received, accepted and/or acknowledged the claim submission within the timely filing period.
   - **Requirements for paper claims:** Submit a screenshot from your software that shows the date the claim was submitted. Please verify the date is within the timely filing period. The screenshot must show the correct member name and correct date of service as well.

2. **Closed or held for additional information – Please attach a copy of all information requested and include the following information on the first page of the request:**
   - Member name, address, and member ID number
   - Provider name and address
   - Claim reference number

3. **Denied for coordination of benefits information –** Submit professional claims at the line level if the primary payer provides the information and submit institutional claims at either the line or claim level. The service level and claim level should be balanced. Optum follows Health Care Claim Encounter – Professional (837p) and Institutional 837I guidelines. *(Additional information on next page.)*

Commercial coordination of benefits claim requirements

- *Primary payer paid amount* – Submit the primary paid amount for each service line from the electronic remittance advice (835) or provider remittance advice (PRA). Submit the paid amount on institutional claims at the claim level.
- *Adjustment group code* – Submit the other payer's claim adjustment group code. Common reasons for the other payer paying less than billed include the deductible, coinsurance, copayment, contractual obligations and/or non-covered services.
- *Adjustment reason code* – Submit the other payer's claim adjustment reason code. Common reasons for the other payer paying less than billed include deductible, etc.
- *Adjustment amount* – Submit the other payer's monetary adjustment amount.

Medicare primary coordination of benefits claim requirements

- *Adjustment group code* – Submit Medicare's claim adjustment group code from the 835 or PRA. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include deductible, coinsurance, copayment, contractual obligations and/or non-covered services.
- *Adjustment reason code* – Submit Medicare's claim adjustment reason code from the 835 or PRA. At the claim level, do not enter any amounts included at the line level.
- *Adjustment amount* – Submit Medicare's monetary adjustment amount.
- *Medicare paid amount* – Submit Medicare's claim level and line level paid amounts.
- *Medicare approved amount* – Submit Medicare's claim level and line level allowed amounts.
- *Member responsibility amount* – Submit the monetary amount for which the member is responsible from the 835 or the PRA.
- *Medicare acceptance of assignment* – Indicate whether the provider accepts the Medicare assignment.

4. **Rate applied incorrectly resulting in overpayment or underpayment –** Network providers should check your fee schedules online prior to submitting a claim reconsideration request for this reason. Indicate the contract amount expected by code or case rate, compared to the amount received, as well as other factors related to the overpayment or underpayment. If you disagree with the fee schedule your claim was paid by, contact your Provider Advocate.

5. **Resubmission of prior notification/prior authorization information –** Please let us know if the service was performed on an emergency basis and notification was not possible. Or, submit a prior authorization number and other documents that support your request. If you spoke to a customer service representative and were told that notification was not required, please submit the date, time and reference number of that call and the name of the representative.

6. **Resubmission of a claim with bundled services –** If a bundled claim appears to be paid incorrectly, please review your claim submission for appropriate codes and modifiers. Otherwise, include an explanation of why the bundling is incorrect.

7. **Other –** Provide any information that supports your request.