Provider Dispute Resolution Request Form

Instructions

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing Description of Dispute and Expected Outcome.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to:

  UnitedHealthcare | March Vision Care
  Attn: Medicaid Vision Appeals
  PO Box 30988
  Salt Lake City, UT 84130
- This form does not apply to the state of New Jersey.

Provider name*:	Provider Tax ID # / Medicare ID #*:
Provider address:	
Provider type: ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other (please specify):	

Claim Information ☐ Single ☐ Multiple “Like” Claims (Complete attached spreadsheet) # of claims: ___________

Patient name*:	Date of birth:	
Health Plan ID number*:	Patient account number:	Original Claim ID number: (If multiple claims, use attached spreadsheet):
Service "from/to" date*: (required for claim, billing, and reimbursement off overpayment disputes):	Original claim amount billed:	Original claim amount paid:
Dispute Type: ☐ Claim ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Disputing Request for Reimbursement of Overpayment	☐ Seeking Resolution of a Billing Determination ☐ Contract Dispute ☐ Other:	
Description of dispute:		
Expected outcome:		

Contact name (print): ________________________ Title: ____________________ Phone #: ___________________

Signature: _________________________________ Date: ____________________ Fax #: ______________________

☐ Check here if additional information is attached. Please do not staple.

For UnitedHealthcare | March Vision Care use only.

Tracking #: Provider ID:

Contracted: Non-contracted:

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For use with multiple “like” claims

Number	Member last name	Member first name	Date of birth	Health plan ID #	Original claim ID #	Service from/to date	Original claim amount billed	Original claim amount paid	Expected outcome
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

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☐ Check here if additional information is attached. Please do not staple.