Optum Provider First-Level Appeal Request

To appeal the denial or reduction of a claim or service, complete the following form and mail or fax to Optum along with supporting documentation. Instructions for this form are on the second page. Emailed forms will not be accepted. All fields are required. Conflicting or missing information may result in delay or denial of your appeal request.

Mail completed form to:

Optum Alaska
Attn: Appeals & Grievances
911 W. 8th Avenue, STE 101
Anchorage, Alaska 99501
Fax: 855-508-9353

PROVIDER INFORMATION	1. Provider Group Name: _____ 2. Alaska Medical Assistance ID: _____ 3. Contact Name: _____ 4. Phone Number: _____ 5. Email Address: _____

MEMBER AND CLAIM INFORMATION **NOTE:** Only a single date of service may be appealed unless services exceed 24 hours (e.g., inpatient hospital stay).	6. Member Name: _____ 7. Alaska Medical Assistance Member ID: _____ 8. Date of Service Related to this Appeal: _____ 9. Service(s) or Procedure(s) Related to this Appeal: _____ _____ _____

PROVIDER CHECKLIST Please attach all of the following documents. Only single sided documents will be accepted.	10. Original Claim (Red/White) ☐	12. Remittance Advice that includes appealed claim ☐
	11. Supporting Medical Documentation (e.g., physician and/or progress notes, referrals, prescriptions, run sheets) ☐	13. Third Party Liability Explanation of Benefits (EOB, EOMB), if applicable ☐

14. REASON FOR REQUEST AND ADDITIONAL INFORMATION:

rev 03.02.21

Optum Provider First-Level Appeal Request Instructions

Submission Requirements: This Optum First-Level Appeal Request must be completed to appeal the denial or reduction of a claim or service. All fields are required. Mail the completed form with all required and applicable documentation to the following address. Emailed, or telephone requests will **not** be accepted.

Optum Alaska
911 W. 8th Ave Ste 101
Anchorage, Alaska 99501
Fax: 855-508-9353

Provider Information:

1. **Provider Group Name:** Enter the provider group name.

   NOTE: If you do not have a provider group name, enter your provider name.

2. **Alaska Medical Assistance ID:** Enter the provider's Alaska Medical Assistance ID number as recorded on the appealed claim.

3. **Contact Name:** Enter the name of the person Conduent should contact regarding this request.

4. **Phone Number:** Enter the phone number of the person to be contacted.

5. **Email Address:** Enter the contact person's email address.

Member and Claim Information:

6. **Member Name:** Enter the member's last name, first name, and middle initial as shown on their member eligibility card.

7. **Alaska Medical Assistance Member ID:** Enter the member's Alaska Medical Assistance Member ID number.

8. **Date of Service Related to this Appeal:** Enter the date of service that applies to this request.

   NOTE: Only a single date of service may be appealed unless services exceed 24 hours (e.g., an inpatient hospital stay).

9. **Service(s) or Procedure(s) Related to this Appeal:** Enter the code(s) for services or procedures that you are requesting an appeal for denial or reduction of payment.

Provider Checklist:

NOTE: Follow this checklist to ensure that all required documentation is attached and will be submitted with the request.

10. **Red and White Claim:** Check this box to indicate you have attached a completed red and white claim form with all necessary corrected information.

11. **Supporting Medical Documentation:** Check this box to indicate that you have attached all medical justification documents and medical records that apply to this request.

12. **Remittance Advice:** Check this box if you have attached Remittance Advice (RA) related to the request.

13. **Third Party Liability Explanation of Benefits** *(if applicable):* Check this box if you have attached a Third Party Liability (TPL) Explanation of Benefits (EOB) to this request.

    NOTE: Attach TPL EOB if patient has TPL or if denial is related to Third Party Liability.

Reason for Request:

14. **Reason for Request:** Enter the reason that you are filing this request as well as any additional information you think may be helpful in processing your request.