

## PROVIDER *DISPUTE/APPEAL* RESOLUTION REQUEST

<b>*CONTACT FULL NAME/ADDRESS/PHONE NUMBER</b> _____ _____ _____ _____	<b>*PROVIDER NPI NO.</b> _____	<b>*CLAIM TYPE:</b> (1) PHARMACY <input type="checkbox"/> (2) PHYSICIAN <input type="checkbox"/> (3) HOSPITAL INPATIENT <input type="checkbox"/> (4) HOSPITAL OUTPATIENT <input type="checkbox"/> (5) LTC <input type="checkbox"/> (6) VISION <input type="checkbox"/> (7) ALLIED/DME <input type="checkbox"/>
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\*RESOLUTION REQUEST TYPE       DISPUTE       APPEAL

**INSTRUCTIONS:**

- Please complete this form if you are seeking reconsideration of a previous claims determination.
- **Dispute** request is for reconsideration of the original claim that has been previously denied and underpaid.
- **Appeal** request is for reconsideration of previously disputed claim(s) that was rejected, denied or underpaid.
- Fields with an asterisk (\*) are required. Please provide the Contacts full information or the resolution letter will be mailed to the address on file.
- Multiple "LIKE" Claims are for Disputes ONLY, and to be used for same provider but different members and dates of service.
- Be specific when completing the Description of Dispute/Appeal and Expected Outcome.

\*CLAIM INFORMATION       SINGLE       MULTIPLE "LIKE" CLAIMS

**\*REASON FOR DISPUTE/APPEAL** (ENCLOSE ALL SUPPORTING DOCUMENTS, INCLUDING CLAIM COPY.)

**\*EXPECTED OUTCOME:**

*PATIENT NAME:	*ID NUMBER:	*CCN NUMBER:	*DATE OF SERVICE:

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE AND COMPLETE.

  
  

SIGNATURE	DATE
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