

PROVIDER DISPUTE/APPEAL RESOLUTION REQUEST

ADDRESS TO WHICH RESPONSE SHOULD BE SENT:			CLAIM TYPE: (1) Pharmacy
			(2) Physician (3) Hospital Inpatient (4) Hospital Outpatient (5) LTC (6) Vision (7) Allied/DME
RESOLUTION REQUEST TYPE:	☐ DISPUTE ☐	APPEAL	
INSTRUCTIONS: - Fields with an asterisk (*) are required - Please complete this form if you are se - Dispute request is for reconsideration - Appeal request is for reconsideration of - Multiple "LIKE" Claims are for Disputes - Be specific when completing the Descri	eking reconsideration of a previou of the original claim that has been of previously disputed claim(s) that s ONLY, and to be used for same pro	s claims determination. previously denied and underpaid. was rejected, denied or underpaid. ovider but different members and date	
CLAIM INFORMATION:	☐ SINGLE ☐	MULTIPLE "LIKE" CLAIMS	
EXPECTED OUTCOME:			
PATIENT NAME:	MEMBER ID NUMBER:	CLAIM CONTROL NUMBER (CCN): DATE OF SERVICE:
THIS IS TO CERTIFY THAT THE INFOR	MATION CONTAINED ABOVE IS	TRUE, ACCURATE, AND COMPLETE	<u> </u>
SIGNATURE		DATE	