

## PROVIDER DISPUTE RESOLUTION REQUEST

 $\square$ No

- Please complete the below form. Fields with an asterisk (\*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Mail the completed form, along with any required supporting documentation to:

American Health Advantage of Utah 201 Jordan Road, Suite 200 Franklin, TN 37067 Toll-Free: 1-855-521-0627

\*Provider NPI:

\*Provider Name:

\*Provider Address:

Provider Type:

□ Yes

| Provider Type:  |                          |                               |
|---|--------------------------|-------------------------------|
| ☐ SNF   | ☐ Hospital               |                               |
| ☐ Ambulance   | ☐ DME                    |                               |
| ☐ Rehab   | ☐ Other(Please specify): |                               |
| CLAIM INFORMATION:   Single   Multiple (please provide listing) |                          |                               |
| Number of Claims:   |                          |                               |
| *Patient Name:  |                          |                               |
| *Health Plan ID Number:   |                          | Claim Number:                 |
| *Date of Service:   |                          | Original Claim Amount Billed: |
| DISPUTE TYPE:   |                          |                               |
| ☐ Claim Denial  |                          |                               |
| ☐ Disputing Request for Reimbursement of Overpayment            |                          |                               |
| ☐ Disputing Underpayment of Claim Paid                          |                          |                               |
| ☐ Other:  |                          |                               |
| *DESCRIPTION OF DISPUTE:  |                          |                               |
|   |                          |                               |
|   |                          |                               |
| EXPECTED OUTCOME:   |                          |                               |
|   |                          | ,                             |
| Contact Name:   |                          | Title:                        |

☐ Mark here if additional information is attached (please do not staple)

Note: Non-Par Providers have 60 days from denial date to file appeal for post service claims.

Par Providers have 180 days from date of Explanation of Payment (EOP) to file a dispute resolution request.

Date:

Fax #:

Signature:

Phone#: