# PROVIDER DISPUTE RESOLUTION REQUEST

**INSTRUCTIONS**

- 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. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the complete form to: **AmericasHealth Plan**
  PO Box 869142 Plano, TX 75086

| | |
|---|---|
| *Provider NPI: | Provider Tax ID: |
| *Provider Name: | |
| *Provider Address: | |

**Provider Type:** ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC

☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(Please specify type of "other")

**CLAIMS INFORMATION** ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) Number of claims: _____

| | | |
|---|---|---|
| *Patients Name: | | Date of Birth: |
| *Health Plan ID Number: | Patient Account Number: | Original Claim ID Number: (If multiple claims, use attaches spreadsheet) |
| Service "From-To" Date: (*Required for Claim, Billing, and Reimbursement of 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:

***DISCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

| | | |
|---|---|---|
| Contact Name (please print) | Title: | Phone number: |
| Signature: | Date: | Fax Number: |

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

**ICE Approved 10/05/07. Effective 01/01/08**

For Health Plan/RBO Use Only

TRACKING NUMBER_____PROVIDER ID#_____

CONTRACTED_____ NON-CONTRACTED_____

# PROVIDER DISPUTES RESOLUTION REQUEST

## For use with Multiple "like" Claims (claims disputed for the same reason)

| | *Patient Name | | Date of Birth | *Health Plan ID Number | Original Claim ID Number | *Service from – To Date | Original Claim Amount Billed | Original Claim Amount Paid |
|---|---|---|---|---|---|---|---|---|
| | Last | First | | | | | | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
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| 14 | | | | | | | | |
| 15 | | | | | | | | |

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**