PROVIDER DISPUTE RESOLUTION FORM

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.
- For routine follow-up status, instead of the Provider Dispute Resolution Form, please [indicate whether your organization uses a Claims Follow-Up Form or indicate how providers should inquire on claims status, e.g., customer service phone number].
- Mail the completed form to: Claims
  P.O. Box 472377
  Aurora, CO 80047

*PROVIDER NAME:	*PROVIDER TAX ID # / NPI #:
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")

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

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached 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:

*** DESCRIPTION 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)**

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

Number	* 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	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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