

# 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

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / NPI #:</b>
<b>PROVIDER ADDRESS:</b>	

**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:* \_\_\_\_\_

<b>* Patient Name:</b>		<b>Date of Birth:</b>	
<b>* Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)	
<b>Service "From/To" Date:</b> ( * Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>	

**DISPUTE TYPE**

<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

<b>Contact Name (please print)</b>	<b>Title</b>	(    )
<b>Signature</b>	<b>Date</b>	(    )
		<b>Phone Number</b>
		<b>Fax Number</b>

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

<i>For Health Plan/RBO Use Only</i>	
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)