

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Please complete this form if you are seeking reconsideration of a previous billing determination.
- Disputes must be sent within **60** days from the paid date on the claim.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Fax or Mail the completed form to:

Simpra Advantage-Provider Disputes
P.O. Box 23607
Tampa, FL 33623-3607

Fax: 659-202-7967

*PROVIDER NAME:	*PROVIDER NPI #:
PROVIDER ADDRESS:	

***CLAIM INFORMATION** Single Similar Multiple Claims (complete attached spreadsheet)

* Patient Name:		Date of Birth:	
* Health Plan Member 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:

<p>DISPUTE TYPE</p> <p><input type="checkbox"/> Payment Dispute</p> <p><input type="checkbox"/> Medical Necessity / Utilization Management</p> <p><input type="checkbox"/> Other</p>

* 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 additional information)

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple claims (disputed for the same reason)

*PROVIDER NAME:

*PROVIDER NPI #:

Number	* Patient Name		Date of Birth	* Health Plan Member 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 additional information)