SimpraAdvantage
Alabama's Healthplan

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: *Submission of this form constitutes agreement not to bill the patient during the dispute resolution process.*

INSTRUCTIONS

- Complete the form below. Fields with an asterisk (*) are required.
- Complete this form if you are seeking reconsideration of a previous billing determination.
- Disputes must be sent within **65** days from the paid/denied notification date for the claim.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support 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 Claim ☐ Multiple Claims

***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:**		

***Contact Name (please print)**	**Title**	**( ) *Phone Number**
Signature	***Date**	**( ) *Fax Number**

***Description of Dispute**
***Expected Outcome**

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

Last Update: 10/2/26

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

Last Update: 10/2/26