

Provider Dispute Resolution Request Form

Instructions:

Please fully complete the form. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Please provide supporting documentation to support your appeal.

Mail the completed form to:

Today's Options
 Provider Dispute Resolution
 4888 Loop Central Drive, Suite 700
 Houston, TX 77081

Or fax the completed form to:

1-713-972-0247

Provider Name: _____

Provider Tax ID#/Medicare ID#: _____

Provider Address: _____

Provider Type: MD Mental Hospital Hospital ASC SNF
 DME Rehab Home Health Ambulance
 Other (Please Specify) _____

Claim Information: Single Multiple "LIKE" Claims (please provide listing)
 Number of Claims _____

*Patient Name:		Date of Birth:
*Health Plan ID Number:	Patient Account Number:	Original Claim ID Number <i>(If multiple claims, please provide separate listing)</i>
*Service "From/To" Date:	Original Claim Amount Billed:	Original Claim amount Paid:
Dispute Type:		
<input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity <input type="checkbox"/> Request or Reimbursement of Overpayment		<input type="checkbox"/> Seeking Resolution of billing Determination <input type="checkbox"/> Other
*Description of Dispute:		
*Expected Outcome		

 Contact Name (Please Print)

 Title

 Phone Number

 Signature

 Date

 Phone Number

Check if additional information is attached.