

**PPO Medicare Advantage  
Preferred Provider Plan**

## 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 PPO  
Provider Dispute Resolution  
4888 Loop Central Drive, Suite 700  
Houston, TX 77081

**Or fax the completed form to:**

1-713-978-5703

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"/> Seeking Resolution of billing Determination
<input type="checkbox"/> Appeal of Medical Necessity		<input type="checkbox"/> Other
<input type="checkbox"/> Request or Reimbursement of Overpayment		
*Description of Dispute:		
*Expected Outcome		

\_\_\_\_\_  
Contact Name (Please Print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

Check if additional information is attached.