



# Provider Claim Dispute Form

Provider Name: \_\_\_\_\_ Provider NPI Number: \_\_\_\_\_

## Claim Dispute Information

Claim Number: \_\_\_\_\_ Date(s): \_\_\_\_\_

Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

Date Claim Denied: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Service Denied: \_\_\_\_\_

Attach a copy of the waiver signed and dated by the Advanced Health member if this relates to a claim for non-covered services.

## Reason/Issue for Dispute

**Claim Denied – No Authorization:**

No authorization was required

Authorization obtained # \_\_\_\_\_

**Claim denied – not filed timely:**

Please attach proof of timely filing.

**Paid to incorrect provider:**

**Incorrect payment amount:**

Please attach an explanation.

**Claim denied – clinical reason:**

Please attach documentation of review by a licensed clinician and the specific reason why that clinician disagrees with Advanced Health’s decision.

**Other:**

Please attach an explanation.

## Batch Submission of Similar/Like Disputed Claims

Provider Name: \_\_\_\_\_ Provider NPI Number: \_\_\_\_\_

# of Claims attached: \_\_\_\_\_ Control Claim Numbers: \_\_\_\_\_

Please attach an explanation. *(No more than 10 at a time)*

## Submit Completed Form(s) and Attachments To:

**Advanced Health**

**ATTN: Claim Appeals**

**289 LaClair Street**

**Coos Bay, OR 97420**

**OR**

Email [claim.appeals@advancedhealth.com](mailto:claim.appeals@advancedhealth.com)

