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

AdvancedHealth
Bridging the Future of Healthcare