PROVIDER CLAIMS BASED DISPUTE RESOLUTION REQUEST

Mail to: Provider Dispute Resolution
P.O. Box 1850 Hicksville, NY 11802-1850

INSTRUCTIONS

- This form is to be used only for payment issues caused by administrative reasons. Please check provider manual for more details.
- Fields with an asterisk (*) are always required.
- All disputes must include Carelon issued Explanation of Payments (EOPs) or Provider Summary Vouchers (PSVs) that tie to the claim iteration(s) that you are disputing. If you did not receive an EOP or PSV from us for the claim that you are trying to dispute, then it must be clearly stated in the description of the dispute.
- Carelon Behavioral Health must receive your appeal request within 60 days from the date of the PSV notice.
- For disputes with more than one (1) member, please use the attached form or your own spreadsheet in the same format.
- Please note that a request for appeal is not considered complete until all necessary information has been received, at a minimum, the name of the patient for whom a denial is being appealed or a valid member number for the patient, and the dates for which a denial is being appealed.

***PROVIDER NAME:**	***PROVIDER TAX ID #:**
***PROVIDER MAILING ADDRESS:**	

*** CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:

Patient Name:		**Date of Birth:**
Member ID Number:	**Service "From/To" Date:**	**Claim Line ID Number** Record ID (Rec. ID) as shown on the Carelon EOP or the Original Claim ID Number on the PSV.
	Original Claim Amount Billed:	**Original Claim Amount Paid:**

***CLAIM BASED DISPUTE TYPE**

- ☐ Paid at incorrect rate.
- ☐ Incorrect interest payment
- ☐ Incorrect denial for no coverage or not a covered benefit
- ☐ Incorrect denial for clinicial profile issues.
- ☐ Incorrect denial for authorizations loaded incorrectly.
- ☐ Other:

*** DESCRIPTION OF DISPUTE:**

*** EXPECTED OUTCOME:**

Contact Name (please print) | **Title** | **Phone Number**

Signature | **Date** | **Fax Number**

Email

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

For Carelon Use Only
TRACKING NUMBER PROVIDER ID#

carelon

PROVIDER CLAIMS BASED DISPUTE RESOLUTION REQUEST
Multiple Claims Denied for the Same Reason

#	* Patient Name		Date of Birth	* Member ID Number	Rec ID. (Claim Line ID) Number	*Service From/ToDate	*Claim Line Amount Billed	*Claim Line Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

* are required fields.