PROVIDER DISPUTE RESOLUTION REQUEST FORM
INFORMATION SUPPLEMENT

What is a Provider Dispute?

A provider dispute is a written notice from a provider that challenges, appeals, or requests consideration in any of the following categories:

- **Claim** (including a bundled group of similar claims) that were previously denied, adjusted or contested
- **Billing Determination**
- **Appeal of Medical Necessity** (Appeal of a Clinical Decision)
- **Utilization Management Decision** (e.g. Appeal of an Administrative Decision such as Eligibility or Benefit Coverage)
- **Request For Reimbursement of Overpayment**
- **Contract Dispute** or other billing determination
- Any **Other** category of dispute that does not fall into any of the above categories

To submit a provider dispute, complete the attached form. Check the appropriate **category** under **DISPUTE TYPE** when submitting this form. Disputes must include:

- Provider's Name / ID Number
- Contact information including phone number
- The number assigned to the original claim (on the EOB)

Unless required by any state or federal law or regulation, **provider disputes must be received within 365 days** from denial or payment determination or in the case of inaction, within 365 days of the time for contesting or denying claims.

Can a dispute be submitted by the Provider on a member's behalf?

Any Disputes submitted on behalf of a member are processed through the member appeal process, as long as the member has authorized the provider to appeal on their behalf

Members have the right to authorize a representative to act on their behalf at any level of the grievance/appeal process. A signed authorization is not required if the grievance/appeal is submitted by he parent, guardian, conservator, relative or other designee (Provider) of the member if the member is a minor, or incompetent or incapacitated.