AMERICAN HEALTH ADVANTAGE OF FLORIDA

# PROVIDER DISPUTE RESOLUTION REQUEST

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Mail the completed form, along with any required supporting documentation to:

American Health Advantage of Florida
201 Jordan Road, Suite 200
Franklin, TN 37067
Toll-Free: 1-855-521-0626
Or Fax to 1-844-280-5360

| | |
|---|---|
| *Provider NPI: | *Provider Tax ID: |
| *Provider Name: | Contracted: ☐ Yes ☐No |
| *Provider Address: | |
| Provider Type:<br>☐ SNF ☐ Hospital<br>☐ Ambulance ☐ DME<br>☐ Rehab ☐ Other(Please specify): _____ | |
| CLAIM INFORMATION: ☐ Single ☐ Multiple (please provide listing)<br>Number of Claims: _____ | |
| *Patient Name: | |
| *Health Plan ID Number: | Claim Number: |
| *Date of Service: | Original Claim Amount Billed: |
| DISPUTE TYPE:<br>☐ Claim Denial<br>☐ Disputing Request for Reimbursement of Overpayment<br>☐ Disputing Underpayment of Claim Paid<br>☐ Other: _____ | |
| *DESCRIPTION OF DISPUTE: | |
| EXPECTED OUTCOME: | |
| Contact Name: | Title: |
| Signature: | Date: |
| Phone#: | Fax #: |

☐ Mark here if additional information is attached (please do not staple)

**Note**: **Non-Par Providers have 60 days from denial date to file appeal for post service claims.**
**Par Providers have 180 days from date of Explanation of Payment (EOP) to file a dispute resolution request.**