



## 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: <input type="checkbox"/> Yes <input type="checkbox"/> No
*Provider Address:	
Provider Type: <input type="checkbox"/> SNF <span style="margin-left: 150px;"><input type="checkbox"/> Hospital</span> <input type="checkbox"/> Ambulance <span style="margin-left: 100px;"><input type="checkbox"/> DME</span> <input type="checkbox"/> Rehab <span style="margin-left: 100px;"><input type="checkbox"/> Other(Please specify): _____</span>	
CLAIM INFORMATION: <input type="checkbox"/> Single <input type="checkbox"/> Multiple (please provide listing) Number of Claims: _____	
*Patient Name:	
*Health Plan ID Number:	Claim Number:
*Date of Service:	Original Claim Amount Billed:
DISPUTE TYPE: <input type="checkbox"/> Claim Denial <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment <input type="checkbox"/> Disputing Underpayment of Claim Paid <input type="checkbox"/> 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.