

# PROVIDER PAYMENT DISPUTE FORM

TODAY'S DATE: \_\_\_\_\_

ENROLLMENT:  Medicaid  CHIP/CHIP P  Marketplace  Medicare Advantage

- **MEMBER APPEAL:** DO NOT use this Provider Payment Dispute form to submit an appeal on behalf of a Member for a denied authorization before rendering service.
- **CORRECTED CLAIMS:** SEND corrected claims as normal claim submissions electronically. This includes claims with primary payer information and Explanation of Payment (EOP). Any corrected claims received as appeals will NOT be processed.
- **MEDICAID/CHIP:** Submit claim reconsideration/payment dispute within **120** days from the date of denial.
- **MARKETPLACE/HMO D-SNP:** Submit claim reconsideration/payment dispute within **180** days from date of denial.

## MEMBER INFORMATION

Member ID Number	Member Name	Member DOB

## PROVIDER INFORMATION

Group/Practice Provider Name	Tax ID	Group Provider NPI
Rendering Provider Name	Rendering Provider NPI	
Office Contact	Contact Phone Number	Contact Fax Number
Contact Mailing Address		

## CLAIM INFORMATION

Claim Number	Date of Service	Billed Amount
Claim Number	Date of Service	Billed Amount

## REASON FOR CLAIM RECONSIDERATION / PAYMENT DISPUTE

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided on the Community Health Choice determination letter or Explanation of Payment.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Exceeded timely filing                                 | <input type="checkbox"/> Claim code editing denial             | <input type="checkbox"/> Denied as duplicate  |
| <input type="checkbox"/> No authorization                                       | <input type="checkbox"/> Denial related to provider data issue | <input type="checkbox"/> Denied for Other Health Insurance but member doesn't have Other Health Insurance |
| <input type="checkbox"/> Disagree that you were paid according to your contract | <input type="checkbox"/> Member retro-eligibility issue        | <input type="checkbox"/> Data elements on the claim on file does not match the claim originally submitted |
| <input type="checkbox"/> Other:   |  |   |

A **payment dispute** is a request from a health care provider to change a decision made by Community Health Choice related to claim payment for services already provided. A provider payment dispute is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

**Medicare Advantage:** A non-contracted Provider, on his or her own behalf, may request a reconsideration for a denied claim only if the non-contract provider completes a Waiver of Liability (WOL) statement, which provides that the non-contracted Provider will not bill the enrollee regardless of the outcome of the appeal.

**Include copy of Community Health Choice EOP along with all supporting documentation, e.g., office notes, authorization and practice management print screens. Submit directly via e-mail or mail to:**

**E-mail:** [ProviderWebInquiries@CommunityHealthChoice.org](mailto:ProviderWebInquiries@CommunityHealthChoice.org)

**Mail:** Community Health Choice  
Attn: Claims Payment Reconsideration  
2636 S. Loop West, Suite 125  
Houston, TX 77054