PROVIDER CLAIMS PAYMENT APPEAL FORM

COMMUNITY HEALTH CHOICE

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 (STAR/STAR+PLUS) /CHIP:** Submit claims resubmissions/payment disputes within **120** days from the date of denial.
- **MARKETPLACE:** Submit claims resubmissions/payment disputes within **180** days from the date of denial.
- **HMO D-SNP:** Submit claims resubmissions/payment disputes within **180** days (PAR providers)/ **60** days (Non-PAR providers) 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

If you have additional claims, please include a separate list with details and reason(s) for dispute.

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

REASON FOR CLAIM RESUBMISSION / 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.

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

Phone: (713) 295 - 2295

Fax: (713) 295 - 5016

Mail: Community Health Choice
Attn: Claims Payment Reconsideration
4888 Loop Central Dr, Suite 600
Houston, TX 77081