

Provider Dispute Resolution Request Form

This form is required for submission of a request for reconsideration or formal appeal of nonpayment of claims. It is **not** to be used for claim status inquiry or coordination of benefits. Claim payment status can be viewed via your account at priorityhealth.com. Provider offices should call the Provider Helpline at 616 942-4765 or 800 942-4765 with any questions.

Do not use this form to submit corrected claims. See the process for submitting corrected claims at priorityhealth.com/provider/manual/billpymt/makecorr.

- Claim Reconsideration** - You believe that a claim has denied or paid incorrectly and you have additional information to be reviewed for adjustment consideration.
- Administrative Appeal** - Your claim has been processed and reconsidered, and you still disagree with the resolution and have additional documentation.
- Medical Review** – Request for retrospective payment review based on an exception to non-covered rules, diagnosis changes, DRG issues, denials for medical necessity or lack of authorization.

Date of request _____ Inquiry / Ref # _____

Contact person _____ Contact phone # or e-mail _____

Patient name _____ Subscriber ID # _____

Provider name _____ Claim # _____

Service date _____ Tax ID # _____

Disputed codes (if applicable) _____

Issue (Required documentation)

Claim Reconsideration		Administrative Appeal		Medical Review	
Clinical edit exception (clinical notes, explanation of exception)		Denial for timely filing (proof of timely filing)		Services denied for authorization, medical necessity (clinical documentation and explanation)	
Claim denied for notes (clinical documentation)		Interest payment (proof of clean claim)		DRG payment (readmission, outlier documentation)	
Claim resubmitted with notes (clinical notes & explanation of issue)		Clinical edit – previously reviewed (new supporting references & explanation)		Benefit exception request for not covered service (clinical documentation & explanation)	
Other:		Other:		Corrected Dx (clinical notes)	
				Other:	

Explanation: (attach letter if necessary)

Send to: **Claim Reconsideration**
1231 East Beltline NE MS 2315
Grand Rapids, MI 49525-4501

Administrative Appeal
1231 East Beltline NE MS 2310
Grand Rapids, MI 49525-4501

Medical Review
1231 East Beltline NE MS 1255
Grand Rapids, MI 49525-4501