

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, coordination of benefits or submission of corrected claims. Claim payment status can be viewed via your account at *priority-health.com*. Provider offices should call the Provider Helpline at 616 942-4765 or 800 942-4765 with any questions.

- Request for 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 # :	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>
Contact Person:	_____	Contact Phone #:	_____
Patient Name:	_____	Subscriber ID # :	_____
Provider Name:	_____	Claim #:	_____
Service Date:	_____	Tax ID #:	_____
Disputed Codes:	_____		

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)		Processing error (copy of claim or RA & explanation)		
	Claim resubmitted with notes (clinical notes & explanation of issue)		Interest Payment (proof of clean claim)		DRG Payment (readmission, outlier documentation)
			Clinical Edit (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:

Reconsideration, Appeal
1231 East Bellline NE MS 2310
Grand Rapids, MI 49525-4501

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