



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 Texas  
 201 Jordan Road, Suite 200  
 Franklin, TN 37067  
 Toll-Free: 1-855-521-0628  
 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 <input type="checkbox"/> Hospital <input type="checkbox"/> Ambulance <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Other(Please specify): _____			
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.