PROVIDER CLAIM DISPUTE FORM

Use this form as part of NH Healthy Families Claim Dispute process to dispute the decision made during the request for reconsideration process.

NOTE**:** Prior to submitting a Claim Dispute, the provider must first submit a "Request for Reconsideration". The Claim Dispute must be submitted within 180 calendar days of the determination letter or EOP from your original request for reconsideration.

All fields in the box immediately below are required information.

Provider Name	Provider Tax ID#
Control (Claim) Number	Date(s) of Service
Member Name	Member (ID) Number

Reason for Dispute (please check):

Claim was denied for no authorization, but authorization #_____ was obtained.
Claim was denied for no authorization, but no authorization is required for this service.
Claim was denied for untimely filing in error (proof of timely filing should be attached).
Claim was paid to the wrong provider
Claim was paid for incorrect amount
Other – please explain: _____

Date of Request:_____Requestor Name: _____
Requestor Phone Number: _____

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled along with the response to your original request for reconsideration.

NOTE: If claim(s) also required a correction, such as a valid procedure code, location code, or modifier, please submit the corrected claim following the "Corrected Claim" process in the provider billing guide. Please do not include this form with a corrected claim.

Mail completed form(s) and attachments to:

NH Healthy Families
Attn: Claims Dispute
P. O. Box 4060
Farmington, MO 63640-3831

Important Notice: NH Healthy Families will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment; or
2. A determination that reprocessing is not appropriate and issuing you a letter to that effect.

(This form may be photocopied)