

Provider Dispute Resolution Request

Individual Family Plan (IFP)

<p>INSTRUCTIONS</p> <ul style="list-style-type: none"> • Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing. • Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. • Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed. • For routine follow-up status, please call 1-800-641-7761. • Mail the completed form to the following address. IFP Provider Disputes and Appeals Unit PO Box 9040 Farmington, MO 63640-9040 	<p>INSTRUCTIONS</p> <p>Please mark the member's line of business:</p> <p><input type="checkbox"/> HMO/POS</p> <p><input type="checkbox"/> PPO</p> <p><input type="checkbox"/> PureCare HSP</p> <p><input type="checkbox"/> PureCare One EPO</p> <p><input type="checkbox"/> CommunityCare HMO</p> <p><input type="checkbox"/> EnhancedCare PPO</p> <p><input type="checkbox"/> PPO Individual and Family</p>
*Provider name:	*Provider tax ID #:
*Provider address	Contracted? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Provider type: <input type="checkbox"/> Physician <input type="checkbox"/> Mental health <input type="checkbox"/> Hospital <input type="checkbox"/> ASC/outpatient services <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab</p> <p><input type="checkbox"/> Home health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other professional (please specify type of other) _____</p>	
<p>*Claim information: <input type="checkbox"/> Single <input type="checkbox"/> Multiple "LIKE" claims (complete attached spreadsheet) Number of claims _____</p>	
*Patient name:	Date of birth:
*Health Plan ID number:	*Subscriber ID/CIN number:
	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:
	Original claim amount paid:
<p>Dispute type: <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of medical necessity/utilization management decision <input type="checkbox"/> Contract dispute</p> <p><input type="checkbox"/> Seeking resolution of a billing determination <input type="checkbox"/> Disputing a request for reimbursement of overpayment <input type="checkbox"/> Other</p>	
<p>*Description of dispute: Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)</p>	
<p>*Expected outcome: (Please provide by claim if multiple.)</p>	

		()
Contact name (please print)	Title	Area code and phone number
		()
Signature and date	Email address	Area code and fax number

Check here if additional information is attached:
(Please do not staple information.)

For Health Plan Use Only

Case# _____

Provider# _____

IFP Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-641-7761.
- Mail the completed form to the following address.

IFP Provider Disputes and Appeals Unit
PO Box 9040
Farmington, MO 63640-9040

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

Check here if additional information is attached:
(Please do not staple information.)

<p>For Health Plan Use Only Case# _____ Provider# _____</p>
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