Provider Claims Dispute Form

Please note this form is not for Member use

(Use a separate form for each patient)

Date:

Provider Information			
Provider Name:			
Provider Tax ID			
Contact Name:		Signature:	
Telephone:		Fax:	
Address:			
City:	State:	Zip:	

Claim Information		
Enrollee Name:		
Enrollee ID:		Enrollee Date of Birth:
Claim Number(s):		Authorization Number:
Date of Service From		Date of Service To
Disputed Amount:		

To ensure timely and accurate processing of your request, please complete this section by checking the applicable determination provided on the Plans determination letter or Explanation of Payment (EOP)

☐ No Authorization on File	☐ Medical Necessity	☐ Timely Filing
☐ Exceeds Authorization	☐ Claim Not Billed as Authorized	☐ Other (please specify)

Dispute Reason

Supporting Documentation

☐ Authorization	☐ Explanation of Benefits (EOB)	☐ Medical Records (only pertinent to this claim)
☐ Proof of Timely Filing	☐ Other (please specify)	

Please return completed form with all relevant supporting documentation to: Simply Healthcare Plans, Grievances and Appeals, 9250 W. Flagler Street, MS 300, Suite 600, Miami, Fl. 33174-3460