ambetter. FROM arizona complete health

PROVIDER REQUEST FOR RECONSIDERATION AND CLAIM DISPUTE FORM

Use this form as part of the Ambetter from Arizona Complete Health Request for Reconsideration/Appeal and Claim Dispute process.

All fields are required information

Provider Name:		**Provider Tax ID #:**	
Control/Claim Number:		**Date(s) of Service:**	
Member Name:		**Member (R/U ID) Number:**	

- A **Request for Reconsideration/Appeal and/or Claims Dispute** is a communication from the provider about a disagreement with the manner in which a claim was processed.
- The Request for Reconsideration/Appeal and/or Claim Dispute must be submitted in writing, which can be mailed, faxed and/or emailed within 365 days from the date on the original EOP or denial.
- *Any photocopied, black & white, or handwritten claim forms, regardless of the submission type (first time or corrected claim) will cause an upfront rejection.*
- If the original claim submitted requires a correction, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. ***Please do not include this form with a corrected claim.***

Type of Request (please check):

- ☐ Request for Reconsideration/Appeal (Attach medical records for code audits, code edits or authorization denials. Do not attach original claim form.)
- ☐ Claim Dispute (Attach any documents that support your request)

Reason for Dispute (please check):

- ☐ Whether the claim was clean (additional information is required to adjudicate the claim. i.e. medical records and etc.).
- ☐ Failure to pay timely.
- ☐ Amount paid (Bundling Software).
- ☐ Amount Paid (Other Than Bundling Software).
- ☐ Coverage under enrollee's policy (e.g. Benefit exclusion, medical necessity, etc.).
- ☐ Claim was denied for no authorization, but authorization # _____ was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Adjustment Request. Network Adequacy (Other than the provider's contract status).
- ☐ Claim was denied for untimely filing in error (attach proof of timely filing (i.e. Clearinghouse acceptance or original claim submissions)).
- ☐ Claim was denied for global/unbundled procedure (attach medical records).
- ☐ Claim was paid to the wrong provider.
- ☐ Claim was paid for the incorrect amount.
- ☐ Systemic or Operational Problems.
- ☐ Other (please explain): _____

Requestor Name: _____

Requestor Phone Number: _____ **Date of Request:** _____

Mail completed form(s) and attachments to the appropriate address:

Ambetter from Arizona Complete Health
Attn: Provider Disputes
PO Box 9040
Farmington, MO 63640-5010