Provider Dispute Form

Date: _____

Please select the dispute type:

☐ **In-Network Provider Dispute:** A disagreement with any adverse action including the denial or reduction of claims for services included on a clean claim. In-network providers may also dispute Absolute Total Care's policies, procedures, rates, contract disputes, or administrative functions.

☐ **Out-of-Network Provider Dispute:** A disagreement with the nonpayment, denial, or reduction of a covered service rendered out of the network, including emergency care.

This form must be used to file your dispute.

Provider/Group Name	Provider Tax ID Number	Provider NPI Number	Provider County	Date of Service	Date of Last EOP
Member Name	**Member ID Number**	**Claim Number***	**Name of Person Completing Form**	**Phone Number**	**Email Address**

*Enter multiple claim numbers

Reason for the Dispute:

In-Network Provider	Out-of-Network Provider**
Any adverse action, including: ☐ Denial of payment of claim (including non-payment) ☐ Denial or reduction of a covered service ☐ Absolute Total Care's Policies and Procedures ☐ Contract disputes ☐ Rates ☐ Other (can include any aspect of Absolute Total Care's administrative functions.	☐ Denial of payment of claim (including non-payment) ☐ Denial or reduction of a covered service rendered out of network, including emergency care **Out-of-network providers may file a dispute only for these reasons

Please explain if reason for dispute is marked "Other":

_____

_____

Please ensure sufficient detail is provided to assist us in the review of your dispute. A copy of the Explanation of Payment (EOP) where applicable and supporting documentation must be submitted with the request.

Mail the completed Provider Dispute Form and all attachments to:

Absolute Total Care
Attn: Provider Disputes
P.O. Box 3050
Farmington, MO 63640-3821