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.

Submitters have 60 calendar days from receipt of notice of an adverse action to file a dispute.

Mail the completed Provider Dispute Form and all supporting documentation to:

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