

A dispute is a request from a health care provider to change a decision made by First Choice VIP Care Plus related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may dispute the claim within **180 days** from the date of the denial or payment.

Submitter contact information	
Name (last, first): _____	Phone number: _____

Provider information	
Name (last, first): _____	Phone number: _____
NPI number: _____	Tax ID: _____
<input type="checkbox"/> I am an in-network provider	<input type="checkbox"/> I am an out-of-network provider

Member information	
Name (last, first): _____	Member date of birth: _____
Member ID: _____	

Claim information	
Claim number: _____	Billed amount: \$ _____
Dates of services: _____	

Provider Claim Dispute Form

To ensure timely and accurate processing of your request, please complete the payment dispute section below by checking the applicable reason for your dispute.

- | | |
|---|--|
| <input type="checkbox"/> Inaccurate payment | <input type="checkbox"/> Denied for no authorization
(service does not require authorization) |
| <input type="checkbox"/> Post-service authorization denial | <input type="checkbox"/> Denied for no authorization
(auth. # _____ on file) |
| <input type="checkbox"/> Denied as a duplicate | <input type="checkbox"/> Untimely filing (proof of timely filing attached) |
| <input type="checkbox"/> Clinical edit limitation or denial | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Denied for no primary payer Explanation of Benefits
(EOB, attached) | |

Signature:	Date:
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Mail this form, a listing of claims (if applicable), and supporting documentation to:

First Choice VIP Care Plus
Attn: Claim Disputes
P.O. Box 7106
London, KY 40742-7106

Important note: A telephone inquiry regarding payment or denial of a claim does not constitute dispute of the claim.