

Provider Dispute Resolution Request Form

Submission of this form constitutes agreement not to bill the patient during the dispute process. Please remember you have 90 days from the date of denial to appeal your claim.

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing the "Description of Dispute" and "Expected Outcome."
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form.

Mail the completed form to: **BlueChoice HealthPlan of South Carolina**
P.O. Box 100148, Columbia, South Carolina 29202-3148

Provider Name*: _____

National Provider Identifier(NPI) Number: _____

Rendering Provider NPI Number: _____

Tax ID Number: _____

Street Address: _____

City: _____ State: _____ ZIP code: _____

Provider Type: MD Mental Health Hospital ASC SNF
 DME Rehab Home Health Ambulance
 Other (please specify): _____

CLAIM INFORMATION

Single Substantially Similar Multiple Claims (complete page 2)

Patient Name*: _____ Date of Birth: _____

Health Plan ID Number*: _____ Patient Account Number: _____

Original Claim ID Number (if multiple claims, complete page 2): _____

Service "From/To" Dates* (required for claim, billing, and reimbursement of overpayment disputes): _____ / _____

Original Claim Amount Billed: _____ Original Claim Amount Paid: _____

DISPUTE TYPE

Claim Seeking Resolution of a Billing Determination Contract Dispute

Request For Reimbursement of Overpayment Appeal of Medical Necessity / Utilization Management Decision

Other (please specify): _____

Description of Dispute*: _____

Expected Outcome: _____

Contact Name (please print): _____ Title: _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Check here if medical records are attached. Please do not staple medical records to this form.

Check here if additional information is attached. Please do not staple additional information.

For Health Plan Use Only: Tracking Number: _____ Provider ID #: _____

Use this page only for multiple "Like" claims (disputed for the same reason). Fields with an asterisk () are required.*

Provider Name*: _____	
National Provider Identifier(NPI) Number: _____	Rendering Provider NPI Number: _____
Tax ID Number: _____	
Street Address: _____	
City: _____	State: _____ ZIP code: _____

1. Patient Name* (Last, First): _____
Date of Birth: _____ Health Plan ID Number*: _____
Original Claim ID Number: _____ Service From/To Date*: _____ / _____
Original Claim Amount Billed: _____ Original Claim Amount Paid: _____
Expected Outcome: _____

2. Patient Name* (Last, First): _____
Date of Birth: _____ Health Plan ID Number*: _____
Original Claim ID Number: _____ Service From/To Date*: _____ / _____
Original Claim Amount Billed: _____ Original Claim Amount Paid: _____
Expected Outcome: _____

3. Patient Name* (Last, First): _____
Date of Birth: _____ Health Plan ID Number*: _____
Original Claim ID Number: _____ Service From/To Date*: _____ / _____
Original Claim Amount Billed: _____ Original Claim Amount Paid: _____
Expected Outcome: _____

4. Patient Name* (Last, First): _____
Date of Birth: _____ Health Plan ID Number*: _____
Original Claim ID Number: _____ Service From/To Date*: _____ / _____
Original Claim Amount Billed: _____ Original Claim Amount Paid: _____
Expected Outcome: _____

5. Patient Name* (Last, First): _____
Date of Birth: _____ Health Plan ID Number*: _____
Original Claim ID Number: _____ Service From/To Date*: _____ / _____
Original Claim Amount Billed: _____ Original Claim Amount Paid: _____
Expected Outcome: _____

- Check here if medical records are attached. Please do not staple medical records to this form.
- Check here if additional information is attached. Please do not staple additional information.