



Provider Claim Dispute

Use this form as part of the IlliniCare Health Claim Dispute process to dispute the decision made during the request for reconsideration process.

NOTE: Prior to submitting a Claim Dispute, the provider must first submit a "Request for Reconsideration". The Claim Dispute must be submitted within **365 calendar days of the date of service.**

ALL FIELDS IMMEDIATELY BELOW ARE REQUIRED INFORMATION

Provider Name: _____ Provider Tax ID#: _____
Control/Claim Number: _____ Date(s) of Service: _____
Member Name: _____ Member (RID) Number: _____

REASON FOR DISPUTE (PLEASE CHECK):

- Claim was denied for no authorization, but authorization # _____ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for untimely filing in error (proof of timely filing should be attached).
- Claim was paid to wrong provider
- PCP Hours didn't fit member need
- Claim was paid for incorrect amount
- Other (please explain below) _____

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

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled along with the response to your original request for reconsideration.

NOTE: If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the provider manual. Please do not include this form with a corrected claim.

MAIL completed form(s) and attachments to:

IlliniCare Health
PO Box 3000
Farmington, MO 63640-3800

IMPORTANT NOTICE: IlliniCare Health will make reasonable efforts to resolve this request within 45 calendar days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you an EOP or letter to that effect.