

A dispute is a request from a health care provider to change a decision made by First Choice VIP Care 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: \$ _____ |
| Date(s) of service(s): _____ | |

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 (see attached) | |

| | |
|-------------------|--------------|
| Signature: | Date: |
|-------------------|--------------|

Mail or fax this form, along with supporting documentation to:

Fax: 1-888-599-1478

Mail:

First Choice VIP Care
Attn: Claim Disputes
P.O. Box 7182
London, KY 40742-7182

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