CONTRACTED PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.

INSTRUCTIONS

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing the description of the DISPUTE AND EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- In order to ensure the integrity of the Provider Dispute Resolution (PDR) process, we will re-categorize issues sent to us on the PDR form which are not true provider disputes.
- Email the completed form to htaclaims@htanc.com

***Provider Name:**	***Provider TaxID #:**

Provider Type: ☐ MD ☐ Mental Health ☐ Hospital ☐ASC ☐ SNF ☐ DME

☐ HH ☐ Ambulance ☐ Other _____

Claims Information ☐ Single ☐ Substantially Similar Multiple Claims (*Complete page 2)*

***Patient Name:**		***Date of Birth**
***Member ID Number**	**Original Claim Number**	**Ticket Number**
***Date of Service**	***Original Billed Amount**	**Original Amount Paid**

Dispute Type

☐ Contract Dispute ☐ Resolution of a Previous Billing Determination ☐ Other

☐ Contracted Provider Post-Service Review for Medical Necessity/Utilization Decision ☐ Claims

Description Of Dispute:

Expected Outcome:

Contact Name _____ Title _____ Phone Number _____

Signature _____ Date _____ Email _____

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Provider Dispute Resolution Request								
For use with Multiple "LIKE" claims (disputed for the same reason)								
Provider Name:					**Provider Tax ID Number**			
Number	***Patient Name**	**Date of Birth**	***Member ID Number**	**Ticket Number**	***Original Claim Number**	***Date of Service To /From**	***Original Amount Billed**	**Original Amount Paid**
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

☐ Check if additional information is attached