HEALTH FIRST
Health Plans

Health First

PROVIDER CLAIM DISPUTE REQUEST

INSTRUCTIONS:

- This form must be returned within **6 months** from the date on the applicable Remittance Advice to initiate the claim dispute process.
- Use on form for each disputed claim.
- Provide a clear rationale for your dispute, and any additional documentation (such as medical records) that will support your request for payment.
- Please allow 30 days to elapse before checking the status of your dispute.
- Mail or fax this form to: Health First Health Plans Fax: (321) 434-5655
  Claims Resolution Unit
  6450 US Highway 1
  Rockledge, FL 32955
- Health First Health Plans will resolve your dispute within **60 days** of receiving this form.
- If the reconsidered decision is in your favor, you will receive a corrected payment and a new Remittance Advice. If the decision is not in your favor, you will receive a letter explaining the reason for the decision.
- **Note:** According to Florida Statute (FS 641.3154) you may not balance bill members of Health Plans during this process.

PROVIDER INFORMATION:

Provider Name:	Phone Number:
Provider Billing Address:	

PATIENT INFORMATION:

Patient Name:	ID#:	Date of Birth:

CLAIM IN DISPUTE:

Date of Service:	Amount Billed:	Amount Paid:	Claim # and Procedure Code:

DISPUTE INFORMATION:

Denial:			**Payment:**
__ Additional Information	__ Pre-Existing	__ COB	__ Contracting
__ Benefit Maximum	__ Timely Filing	__ Duplicate	__ Under/Overpayment
__ Authorization	__ Contracting	__ Eligibility	__ Member Responsibility
Other:			

Authorized Representative Name (please print) Title Date

___Check here if additional information is attached.

Revised: 3/28/2011

Health Plan use only: