# Provider Dispute Claim Reconsideration Request Form

**Today's date** ___________________

## Member Information

Member last name: _________________________ First name: _________________________

Date of birth: _________________________ Member Identification Number: _________________________

## Physician/Health care professional information

Contact name: _________________________ Phone number (with area code):_________________________

Email address: _________________________

Healthcare professional name (as listed on Evidence of Payment "EOP"): _________________________

Tax Identification Number (TIN): _________________________

Facility/Group name: _________________________

Last name: _________________________ First name: _________________________

Street address: _________________________ City: _________________________

State: _________________________ Zip: _________________________

**Reason for request:** Date of service: _________________________ Claim #: _________________________

Total charges: _________________________ Expected amount owed: _________________________

❏ 1. Previously denied / "Exceeds Timely Filing"

❏ 2. Previously denied requesting additional information

❏ 3. Previously denied / "Coordination of Benefits"

❏ 4. Resubmission of corrected claim (requires the CORRECTED claim form to be attached)

❏ 5. Previously adjudicated but applied incorrect rate resulting in over/underpayment

❏ 6. Previously denied for "no authorization"

❏ 7. Other (provide details below)

Comments – reason for appeal: _________________________

_________________________

_________________________

Please include the following: **(1) a copy of the initial claim (2) a copy of the EOP (3) Waiver of Liability form (4) all other documents supporting the appeal request and mail or fax to:**

**ATTN: Appeals & Grievances**
**Clear Spring Health**
**3601 SW 160th Ave, Suite 450**
**Miramar, FL 33027**

**Fax: (866) 235-5181**