PROVIDER DISPUTE CLAIM RECONSIDERATION REQUEST FORM

Clear Spring Health

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: _____

- ☐ Previously denied / "Exceeds Timely Filing"
- ☐ Previously denied requesting additional information
- ☐ Previously denied / "Coordination of Benefits"
- ☐ Resubmission of corrected claim (requires the CORRECTED claim form to be attached)
- ☐ Previously adjudicated but applied incorrect rate resulting in over/underpayment
- ☐ Previously denied for "no authorization"
- ☐ 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
PO Box 3040
Spring Hill, FL 34611

Fax: (866) 235-5181