Anthem

Provider Dispute Resolution Form

Date (mm/dd/yyyy): _____

Requestor Information			
Provider Name:			
Provider # or TIN:			
Office or Practice Name:			
Contact Name:		Signature:	
Telephone:			
Fax:			
Address:			
City:	State:	ZIP:	

Claim Information		
Patient Name:		Subscriber Name:
Patient ID #:	(include prefix or suffix if applicable)	
Claim Number(s):		
Date(s) of Service:		
Billed Amount:		Disputed Amount:
Process Date:		

Reason

- ☐ Clinical Edit/Bundling
- ☐ No Authorization/Referral # on File
- ☐ No Hospital Notification
- ☐ Length of Stay
- ☐ Out–of-network
- ☐ Timely Filing Denial
- ☐ Assistant Surgeon/Surgical Assistant Not Allowed
- ☐ Disagree with Outcome of Claim Action Request
- ☐ Other: _____

Explain:

Supporting Documentation

Please indicate the type of documentation attached. If you are unsure what to attach, please refer to your Provider Manual.

- ☐ Proof of Timely Filing
- ☐ Office/Progress Notes
- ☐ Medical Records
- ☐ Procedure/Operative Report
- ☐ Original Claim Action Request
- ☐ Other: _____

Please do not use this form for government programs.