

Provider Dispute Resolution

Instructions

The Colorado Medical Society has worked in collaboration with payers to standardize the format and required information necessary to request a correction, reconsideration, or review of how your claim was originally processed. This level of resolution is subject to §10-16-705 (13) Colorado Revised Statutes and Colorado Regulation 4-2-23.

Note: This form is to be used for complex issues such as bundling, no preauthorization, and no admission notification denials. For simple problems such as claims correction, please use the Claim Action Request (CAR) form.

- 1) Determine the reason the claim or your CAR was not processed as you expected:
 - a. Review the messages on the Remittance Advice (RA) or Explanation of Payment (EOP).
 - b. Follow-up with Customer Service for clarification.
- 2) Be sure to fill out the form completely and attach a copy of the RA or EOP showing the original processing, as well as any supporting documentation. If you are disputing the result of a CAR, include that original request with your documentation.
- 3) Mail the completed form and attachments to:

Rocky Mountain Health Plans
Provider Dispute Resolution Coordinator
P.O. Box 10600
Grand Junction, CO 81502-5600



Provider Dispute Resolution Form

Date (mm/dd/yyyy): _____

Requestor Information			
Provider Name:			
Provider # or TIN:	NPI #:		
Office/Practice Name:			
Contact Name:		Signature:	
Telephone:			
Fax:			
Address:			
City:		State: CO	Zip:

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

Reason		
<input type="checkbox"/> -Clinical Edit/Bundling	<input type="checkbox"/> -Out of Network	<input type="checkbox"/> -Other: _____
<input type="checkbox"/> -No Authorization/Referral # on File	<input type="checkbox"/> -Timely Filing Denial	
<input type="checkbox"/> -No Hospital Notification	<input type="checkbox"/> -Assistant Surgeon/Surgical Assistant Not Allowed	
<input type="checkbox"/> -Length of Stay	<input type="checkbox"/> -Do Not Agree With Outcome of Claim Action Request	
Explain:		

Supporting Documentation	
(Please indicate what is attached. If you are unsure of what to attach, refer to your Provider Manual.)	
<input type="checkbox"/> -Proof of Timely Filing	<input type="checkbox"/> -Original Claim Action Request
<input type="checkbox"/> -Office/Progress Notes	<input type="checkbox"/> -Other: _____
<input type="checkbox"/> -Medical Records	
<input type="checkbox"/> -Procedure/Operative Report	