

Provider Dispute Resolution

Instructions

Forms are routed to the appropriate department based on the form type. Using the correct form will result in a more timely resolution to your request.

Use this form if you disagree with the outcome of a claim that has been processed. If you are making a correction to a claim such as changing a diagnosis code, changing the date of service, adding a procedure code, etc. please use the Claim Action Request Form.

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.

- Please fill out the Provider Dispute Resolution form when you would like to appeal the outcome of a claim.
- A provider dispute can be requested for denials that include timely filing, clinical editing, preauthorization violations, claim related denials, and adverse determinations such as denied inpatient days, denials for no admission notification, etc.
- Prior to submitting an appeal determine the reason the claim did not process as you expected. Review the denial reason listed on your provider voucher or remittance advice. If you do not have a provider voucher please check claim status online at HealthTrio access|RMHP.
- Fill out the Provider Dispute Resolution form completely and attach a copy of the remittance advice or provider voucher showing the original processing in addition to any supporting documentation.
- 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:	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	