## **Clover Health**

## **Claims Appeal & Dispute Form**

This form is to be used to request a redetermination if Clover Health overpaid, underpaid, or denied your claim. Please fill out every section of this form - if not, your request may be placed on hold until we recieve the correct information.

Provider Information INN OON	Contact Information
Provider/Group Name:	Name:
Tax ID or NPI:	Address:
Patient Information HMO PPO	Phone #: ( )
Patient Name:	Fax #: ( )
Member ID: CP	Claim Information
Attachments	Claim Number:
Remittance Advice Medical Records	Date of Determination* / /
Supporting Documentation for Dispute	Date(s) of Service: / /
Waiver of Liability (REQUIRED for OON)	//
Reason for Request (Please Select One)	
Overpayment 🗌 Underpayment** 🗌 Denial Code(s) 🗌	
Amount Paid: \$ Expected Amount: \$	
Whole Claim:  CPT Code(s):	
Other (Please provide a description)	
Return Information	
INN providers should submit requests to: Mail: PO Box 2092 Jersey City, NJ 07303 Fax: 1-888-240-7243 Secure Email: PO_Box_2092@cloverhealth.com	<b>OON providers should submit requests to:</b> Mail: PO Box 2091 Jersey City, NJ 07303 Fax: 1-732-412-9706 Secure Email: PO_Box_2091@cloverhealth.com

\*Please provide good cause if dispute is filed after 60 days from the date of determination. \*\*Inquiries are considered underpayments only if the whole claim or the code being disputed was initially paid