

Claims Appeal & Dispute Form

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

****Inquiries are considered underpayments only if the whole claim or the code being disputed was initially paid**