



HEALTH ALLIANCE

Offered by simply healthcare

**Provider Claims Dispute Form**  
Please note this form is not for Member use  
(Use a separate form for each patient)

Date:

Provider Information		
Provider Name:		
Provider Tax ID		
Contact Name:		Signature:
Telephone:		Fax:
Address:		
City:	State:	Zip:
Claim Information		
Enrollee Name:		
Enrollee ID:		Enrollee Date of Birth:
Claim Number(s):		Authorization Number:
Date of Service From		Date of Service To
Disputed Amount:		
To ensure timely and accurate processing of your request, please complete this section by checking the applicable determination provided on the Plans determination letter or Explanation of Payment (EOP)		
<input type="checkbox"/> No Authorization on File	<input type="checkbox"/> Medical Necessity	<input type="checkbox"/> Timely Filing
<input type="checkbox"/> Exceeds Authorization	<input type="checkbox"/> Claim Not Billed as Authorized	<input type="checkbox"/> Other (please specify)
Dispute Reason		
Supporting Documentation		
<input type="checkbox"/> Authorization	<input type="checkbox"/> Explanation of Benefits (EOB)	<input type="checkbox"/> Medical Records (only pertinent to this claim)
<input type="checkbox"/> Proof of Timely Filing	<input type="checkbox"/> Other (please specify)	

Please return completed form with all relevant supporting documentation to: Simply Healthcare Plans, Grievances and Appeals, 9250 W. Flagler Street, MS 300, Suite 600, Miami, FL 33174-3460