Provider name: ______________________________ ISS # _________________________

Provider dispute resolution request (For use with multiple "like" claims.)

	*Patient name		*Date of birth	*Health plan ID number	Claim ID number	*Service from/to date	1st level of reconsideration **Comm #**	2st level of reconsideration **Comm #**	Billed amount	Claims status	Provider name NPI and TIN
	Patient last	Patient first									
1											
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☐ Check here if additional information is attached.

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