



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 | Claim amount billed | Claim amount paid | Expected reimbursement amount | Comments |
|----|----------------|-------|----------------|------------------------|------------------|------------------------|---------------------|-------------------|-------------------------------|----------|
| | Last | First | | | | | | | | |
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Check here if additional information is attached

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