



PROVIDER CLAIM DISPUTE FORM

Use this form as part of the Ambetter from Sunshine Health Claim Dispute process to dispute the decision made during the request for reconsideration process.

Note: Prior to submitting a Claim Dispute, the provider must first submit a "Request for Reconsideration". The Claim Dispute must be submitted within **180 days of the date on the determination letter or Explanation of Payment (EOP) from your original request for reconsideration.**

All fields in the box immediately below are required information

Provider Name	Provider Tax ID #
Control/Claim Number	Date(s) of Service
Member Name	Member (RID) Number

Reason for Dispute (please check):

- Claim was denied for no authorization, but authorization # _____ was obtained
- Claim was denied for no authorization, but no authorization is required for this service
- Claim was denied for untimely filing in error (proof of timely filing should be attached)
- Claim was paid to the wrong provider
- Claim was paid for the incorrect amount
- Other (please explain below): _____

Date of Request: _____

Requestor Name: _____

Requestor Phone Number: _____

Note: If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

Mail completed form(s) and attachments to:

Ambetter from Sunshine Health
PO Box 5000
Farmington, MO 63640-5000

Attach a copy of the EOP(s) with Claim(s) to be adjudicated clearly circled along with the response to your original request for reconsideration.

Important Notice: Ambetter from Sunshine Health will make reasonable efforts to resolve this request within 20 calendar days for electronic and 40 calendar days for paper. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you an EOP or letter to that effect.

(This form may be photocopied)