Payment Dispute Form

Number of pages (Including Cover Sheet): _____

Provider Name: _____ NPI/TIN: _____ Date: _____

Providers have the option to use 1 form per Member or list multiple Members on the same form.

	Member ID:	Member Name:	Claim Number(s):	Date(s) of Service:		Billed Amount:	Reason Code(s):
				Start Date:	End Date:		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

Reason Codes:

1. Underpaid / Overpaid
2. Authorization Issues
3. Modifier Issues
4. Denied As A Duplicate
5. Incorrect Coding
6. Other Reasons

Comments:

1.) For claims that are partially paid or denied, please re-submit this form with supporting documents.

a. Copy of the Remittance Advice
b. Copy of the Original Invoice (if applicable)
c. Other requesting documents

2.) To send completed Claims Adjustment Form, please fax to **1-877-809-0783**, e-mail to **Claims_MMP_Medicaid@HealthSpring.com** or mail to:

Attention: Cigna-HealthSpring Payment Dispute Unit
P.O. BOX 211088
Bedford, TX 76095

For any questions, please contact Provider Services at: **1-866-486-6065**.

Payment Disputes are requests to review a previously adjudicated claim. This form is not to be used for corrected claims, or claim appeals. A Payment Dispute request from a PAR/NON-PAR Provider must be filed within 120 days (for Medicaid plans) and 60 days (for Medicare-Medicaid Plans (MMP)) from the date of the disposition or the remittance of Explanation of Payment (EOP). Out of State providers must file within 365 days.