

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.

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