Provider Claim Dispute

illinicare health

Use this form as part of the IlliniCare 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 claims dispute must be submitted within **90 days of paid date, not to exceed 1 year from DOS.**

All fields immediately below are REQUIRED information.

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

Reasons 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 wrong provider
- ○ PCP Hours didn't fit member need
- ○ Claim was paid for incorrect amount
- ○ Other (please explain below)

_____

_____

_____

_____

Request Name:	Requestor Phone Number:
Date of Request:	

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled along with the response to your original request for reconsideration.

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

Updated 3/1/2018

MAIL completed form(s) and attachments to:

IlliniCare Health
PO Box 3000
Farmington, MO 63640-3800

IMPORTANT NOTICE: IlliniCare Health will make reasonable efforts to resolve this request within 45 calendar days of receipt. 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.