For Health Plan/RBO Use Only
Tracking number: _____
Provider ID: _____
Contracted: _____
Non-contracted: _____

vivanthealth

Provider Dispute Resolution Request

Instructions
- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Vivant Health, P.O. Box 869145, Plano, TX 75086

***Provider NPI:**	**Provider tax ID:**
***Provider name:**	
Provider address:	

Provider type: ☐ MD ☐ Mental health professional ☐ Mental health institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home health ☐ Ambulance ☐ Other: _____

Claim information: ☐ Single ☐ Multiple "LIKE" claims *(complete attached spreadsheet)* Number of claims: _____

***Patient name:**	**Date of birth:**
***Health plan ID number:**	**Patient account number:**
Original claim ID number *(if multiple claims, use attached spreadsheet):*	
Service "from/to" date *(*required for claim, billing, and reimbursement of overpayment disputes):*	
Original claim amount billed:	**Original claim amount paid:**

Dispute type:
☐ Claim
☐ Appeal of medical necessity/utilization management decision
☐ Disputing request for reimbursement of overpayment
☐ Seeking resolution of a billing determination
☐ Contract dispute
☐ Other: _____

***Description of dispute:**

Expected outcome:

☐ **Check here if additional information is attached** (please do not staple)

Contact name (please print) | Title | Phone number

Signature | Date | Fax number

24559-12 9/24

Provider Dispute Resolution Request

For use with multiple “LIKE” claims (claims disputed for the same reason)

	*Patient First Name	*Patient Last Name	Patient Date of Birth	*Health Plan ID Number	Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

☐ **Check here if additional information is attached** (please do not staple)