DOCTORS
HEALTHCARE PLANS.INC

Claim Dispute Form

Participating providers may submit a Claim Dispute within one hundred twenty (120) calendar days from the date of the corresponding Remittance Advice. Supporting documentation must include the Remittance Advice and medical records; additional evidence may be required in specific cases. Please allow sixty (60) days for processing.	
Date:	
Claim Information	
Claim ID:	Billed Amount:
DOS:	
Member Information	
Member Name:	Member ID:
DOB:	
Provider Information	
Provider Name:	Tax ID:
Contact Name:	Fax:
e-mail:	Telephone:
Reason for Requesting Review	
☐ Authorization Not Requested	☐ Medical Records Not Requested
☐ Denied Authorization	☐ Timely Filing Limit
☐ Insufficient Authorization	☐ Unlisted Procedure Code
☐ Bundling / Incidentals	☐ Pricing
☐ Other:	
Comments	
ATTACHMENTS	
☐ Remittance Advice	☐ Medical Records & Additional Evidence