



PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Please include a copy of the original claim(s) as well as a copy of the remittance.
- Mail or fax the completed form to:

VNS CHOICE
 Attn: Provider Dispute Resolution
 1250 Broadway, 11th Floor
 New York, NY 10001

Fax – 866-791-2213

*Provider Name:	*Provider NPI:
Provider Address	

Provider Type:

MD		SNF		Ambulance	
Hospital		DME/Supplies		Home	
ASC		Rehab		Other (please specify)	

Claim Information Single Multiple **“LIKE”** Claims (see additional form) *Number of Claims:* _____

*Patient Name		Date of Birth:
*Health Plan ID Number	Patient Account Number	Original Claim Number: (if multiple claims, use attached form)
Service “From/To” Date	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

Claim		Payment Dispute	
Contract Dispute		Dispute of Medical Necessity / Utilization Management Decision	
Other (please specify)			

***DESCRIPTION OF DISPUTE**

EXPECTED OUTCOME

Contact Name:	Title:	Phone:
Signature:	Date:	Fax:

