

Provider Claim Payment Dispute Resolution Form

Use a separate form for each claim.



PROVIDER INFORMATION:

Request Date: ___/___/___ Name: _____

Address: _____

City/State/Zip Code: _____

Telephone: _____ Fax: _____

E-mail: _____ Contact Person: _____

MEMBER INFORMATION:

Name: _____ Member ID#: _____

Date of Birth: ___/___/___ Telephone: _____

Contact Person: _____

REASON FOR REQUEST:

Date of Service: ___/___/___ Place of Service: _____

Claim Number:	Issue:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- Required Attachments:**
- Copy of Provider Remittance Advice PRA or EOB
 - Claim Form (with corrections if necessary)
 - Original Medicare PRA/EOB when needed for proof of payment differences
 - Other required attachments as listed above

Submit completed form and required attachments to:

Bravo Health Claims Reconsideration Team
P.O. Box 26038
Baltimore, MD 21224
Fax: **1-866-885-3785**

Or e-mail completed form and required attachments to: pffsinq@bravohealth.com