carelon Behavioral Health

PROVIDER CLAIMS BASED DISPUTE RESOLUTION REQUEST

Email to: ProviderDisputeResolution@carelon.com
or
Mail to: Provider Dispute Resolution
P.O. Box 1864 Hicksville, NY 11802-1864

INSTRUCTIONS

- This form is to be used only for payment issues caused by administrative reasons. Please check provider manual for more details.
- Fields with an asterisk (*) are always required.
- All disputes **must include** Carelon issued Explanation of Payments (EOPs) that tie to the claim iteration(s) that you are disputing.If you did not receive an EOP from us for the claim that you are trying to dispute, then it must be clearly stated in the description of the dispute. Provide additional information to support the description of the dispute (e.g contract rate if the dispute is related to incorrect payment).
- Please fill out 1 form per member.

*PROVIDER NAME:	*PROVIDER TAX ID # :
*PROVIDER ADDRESS:	

*** CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE"** Claims (complete attached spreadsheet) *Number of claims*:

* Patient Name:		*Date of Birth:
* Member ID Number:	**Service "From/To" Date:	* Original Claim Line ID which is the Record ID (Rec. ID) provided on EOP. (If more than 1, use Multiple Like Claims form)
Health Plan :	Original Claim Amount Billed:	Original Claim Amount Paid:

***CLAIM BASED DISPUTE TYPE**

☐ Paid at incorrect rate.
☐ Incorrect interest payment
☐ Incorrect denial for no coverage or not a covered benefit
☐ Incorrect denial for clinicial profile issues.
☐ Incorrect denial for authorizations loaded incorrectly.
☐ Other:

*** DESCRIPTION OF DISPUTE:**

*** EXPECTED OUTCOME:**

Contact Name (please print)	Title	Phone Number
Signature	Date	Fax Number

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

For Carelon Use Only
TRACKING NUMBER PROVIDER ID#

carelon Behavioral Health

PROVIDER CLAIMS BASED DISPUTE RESOLUTION REQUEST
Multiple "Like" Claims
1 Form per Member

#	* Patient Name		Date of Birth	* Member ID Number	* Rec ID. (Claim Line ID) Number	*Service From/ToDate	*Claim Line Amount Billed	*Claim Line Amount Paid	*Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

* are required fields.