Provider Claims Dispute Form

Please note this form is not for Member use

Date: _____

Provider Information			
Provider Name			
Provider Tax ID			
Contact Name:		Signature:	
Telephone:		Fax:	
Address:			
City:	State:	Zip:	

Claim Information		
Enrollee Name:		
Enrollee ID:		Enrollee Date of Birth:
Claim Number(s):		Authorization Number
Date of Service From:		Date of Service To:
Disputed Amount:		

To ensure timely and accurate processing of your request, please complete this section by checking the applicable determination provided on the Plans determination letter or Explanation of Payment (EOP)

☐Underpayment Request	☐ Medical Necessity	☐ Timely Filing
☐ Contract Application	☐ No authorization on file	☐ Other: _____

Dispute Description Reason

Supporting Documentation	
☐ Authorization	☐ Explanation of Payment
☐ Proof of Timely Filing	☐ Other:

Please return completed form with all relevant supporting documentation to: HealthSun Health Plans, Claims Review Department, P.O Box 330968, Miami, FL 33233-0967