Date­:­\_\_\_\_\_\_\_\_\_\_\_\_

**PROVIDER DISPUTES & APPEAL**

**REQUEST FORM**

* Complete the ENTIRE form below.
* One form per member per provider
* Attach any supporting documentation.
* Incomplete forms will not be processed. Forms will be returned to the submitter.
* For Medicare NON-CONTRACTED providers, include with your **appeal** a fully executed [Waiver of Liability (WOL) Statement](http://ephmedicare.com/wp-content/uploads/2020/01/9912-16-WAIVER-OF-LIABILITY.pdf). If you complete a WOL Statement, you waive the right to collect payment from the member, with the exception of any applicable cost sharing, regardless of the determination made on the appeal.
* Please refer to the Provider Manual for timeframes and more information.
* Mail to:

El Paso Health Advantage Dual SNP

 Attn: Complaints and Appeals Dept

 P.O. Box 971100

 El Paso, TX 79997

 Or

 Fax to: (915) 298-7872

|  |
| --- |
| **Provider Information** |
| **Contact Person:** |  | **Contact Phone #:** |  |
| **Mailing Address:**  |  |
| **Provider Name** |  |
| **Provider NPI** |  | **Provider Tax ID** |  |

|  |
| --- |
| **Member Information** |
| **Member Name** |  | **Member Account #** |  |
| **Member Date of Birth** |  | **Member ID** |  |

|  |
| --- |
| **Claim Information** |
| **Claim Number(s)** |   |
| **Date(s) of Service** |  |

|  |
| --- |
| **Dispute or Appeal Reason** |
| * **Appeal of Medical Necessity/Utilization Mgmt. Decision**
 | * **Claim Authorization Issue**
 |
| * **Requesting Payment**
 | * **Past Timely Filing**
 |
| * **Requesting Additional Payment**
 | * **Other**
 |

**Description of Dispute or Appeal:**

# Corrected Claims can be submitted to our Claims Department.

# H3407 Provider Dispute & Appeal Request Form CY2020\_01