

CLAIM ISSUE FORM

Date:	Provider ID:
Provider Name:	Phone Number:
Email Address:	
Contact Name:	Submitted By:

Please provide the following information regarding the issue:	
Member ID:	Claim Number:
Remittance Number:	Remittance Date:

Please explain the issue you have with the claim:	
<input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> COB/TPL <input type="checkbox"/> Claim processed incorrectly <input type="checkbox"/> Authorization issues <input type="checkbox"/> Referral issues <input type="checkbox"/> Claim paid to the wrong provider <input type="checkbox"/> Duplicate payment	<input type="checkbox"/> Other (explanation required) <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

FOR PHP USE ONLY

Rep. Name:	
Response Date	Comments