



PROVIDER DISPUTE RESOLUTION REQUEST

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Please include a copy of the claim that was previously processed.
- For routine follow-up, please use AZ Connect or call for status (instead of the Provider Dispute Resolution Form).
- Mail the completed form, along with any required supporting documentation to:

Arizona Priority Care
 585 N Juniper Dr, Ste 200
 Chandler, AZ 85226
ATTN: Claims Department

*Provider NPI:		*Provider Tax ID:	
*Provider Name:		Contracted: <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Provider Address:			
PROVIDER TYPE: <input type="checkbox"/> MD/DO <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Mental Health Institutional <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other (<i>Please specify</i>): _____			
*Patient Name:			Date of Birth:
*Health Plan ID Number:	Patient Account Number:	Original Claim ID Number:	
Service "From/To" Date: (<i>*Required for Claim, Billing, and Reimbursement of Overpayment Disputes</i>)	Original Claim Amount Billed:	Original Amount Paid:	
DISPUTE TYPE: <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity/Utilization Management Decision <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment		<input type="checkbox"/> Downcoding/Payment <input type="checkbox"/> Seeking Restitution of a Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Other: _____	
*DISCRIPTION OF DISPUTE:			
EXPECTED OUTCOME:			

Contact Name (<i>Please Print</i>):	Title:
Signature:	Date:
Phone Number:	Fax Number:

Mark here if additional information is attached (*please do not staple*)

For AZPC Only

Tracking Number: _____ Provider ID#: _____
 Contracted: _____ Non-Contracted: _____