Arizona Priority Care™
One Goal. One Priority. Your Healthcare.

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

Contact Name *(Please Print)*:	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: _____