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

Provider Dispute Resolution Request

- Please complete the form in its entirety; *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).

Please return the completed PDR along with any required supporting documentation via email at smart@azprioritycare.com, by fax to (480) 499-8744, or by mailing it directly to Arizona Priority Care, **ATTN: Claims Department**, 585 N Juniper Dr, Ste 150, Chandler, AZ 85226.

***Provider NPI:**	***Provider Tax ID:**	
***Provider Name:**		**Contracted:** ☐ YES ☐ NO
***Provider Address:**		
Provider Type: ☐ Ambulance ☐ ASC ☐ DME ☐ Home Health	☐ Hospital ☐ MD/DO ☐ Mental Health Institute ☐ Mental Health Professional	☐ Rehab ☐ SNF ☐ Other *(Please specify)*: _____
***Patient Name:**		**DOB:**
***Member ID:**	**Pt. Acct. #:**	
Original Claim ID #:	**Service "From/To" Date *(*Required for Claim, Billing, and Reimbursement of Overpayment Disputes)*:**	
Original Claim Amount Billed:	**Original Amount Paid:**	
Dispute Type: ☐ Appeal of Medical Necessity/Utilization Management Decision ☐ Claim ☐ Contract Dispute	☐ Disputing Request for Reimbursement of Overpayment ☐ Down Coding/Payment ☐ Seeking Restitution of a Billing Determination ☐ Other: _____	
***Description of Dispute:**		
Expected Outcome:		
Contact Name *(Please Print)*:		**Date:**
Signature:	**Title:**	
Phone Number:	**Fax Number:**	

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

For AZPC Only	
Tracking Number:	**Provider ID #:**
Contracted:	**Non-Contracted:**