PROVIDER DISPUTE FORM

Use this form if a claim has been processed and a Provider Remittance Advice (PRA) has been issued or if you have received a determination letter subsequent to the initial reconsideration request. **Do not use for first time or corrected claims.** For corrected claims, please use the claims resubmission process outlined in the provider billing manual.

A **Claims Payment Dispute** is defined as a finalized claim in which the provider disagrees with the outcome. See Provider Billing Manual for full description and inclusions.

ALL FIELDS BELOW ARE REQUIRED INFORMATION:

Member's Name:	Member's Medicaid Number:
Date(s) of Service:	Control/Claim Number(s):
Medicaid Remittance Date:	Billed Charge(s):
Provider Name:	Provider TIN Number:
Medicaid Provider Number:	Provider Contact Number:
Contact Name:	Contact Address:

☐ **Claim Payment Reconsideration** is the initial request to investigate the outcome of the finalized claim.

Reconsiderations are accepted in writing within **180 calendar days** from the date of the Explanation of Payment (EOP) or PRA. Any reconsideration requests submitted after 180 calendar days will be considered untimely and denied unless good cause can be validated.

Iowa Total Care will work to resolve reconsideration requests within 30 calendar days of receipt of all information.

☐ **Claim Payment Appeal** may be submitted by Provider if there is a disagreement on the Reconsideration decision.

Appeals are accepted in writing within **30 calendar days** from the date of the reconsideration determination letter or EOP/PRA from a Reconsideration request.

Iowa Total Care will work to resolve appeal requests within 30 calendar days of receipt of all information. **Please mail this form along with relevant claim information and any supporting documentation to the following address:**

Iowa Total Care
Attn: Claim Disputes
P.O. Box 8030
Farmington, MO 63640-0830

This form may be copied.