PROVIDER DISPUTE FORM

Use this form as part of the Iowa Total Care Dispute Process if a claim has been processed and a Provider Remittance Advice (PRA) has been issued. **Do not use for first time claims or corrected claims.** For corrected claims, please use the claims resubmission process outlined in the provider billing manual.

A **Claim Payment Dispute** is defined as a finalized claim in which the provider disagrees with the outcome. Claim payment disputes are submitted for numerous reasons, including, but not limited to:

- Contractual payment Issues
- Reduced or Zero-Paid claims disagreements
- Post-service authorizations
- Claim code-editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Timely filing issues

All requests for claim payment disputes must be submitted within **180 calendar days** from the date of the Explanation of Payment (EOP) or PRA. Any reconsideration submitted after 180 calendar days will be considered as untimely and denied unless good cause can be validated.

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:

Iowa Total Care will work to resolve reconsideration requests within 30 calendar days of receipt of all information. A determination letter will be issued detailing the reconsideration decision including the statement of and reason for action by Iowa Total Care.

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.