michigan complete health

# Provider Claim Dispute

Use this form as part of the Michigan Complete Health (MMP) Claim Dispute process to dispute the decision made during the request for reconsideration process.

**NOTE:** Prior to submitting a Claim Dispute, the provider must first submit a "Request for Reconsideration".

**ALL FIELDS IMMEDIATELY BELOW ARE REQUIRED INFORMATION**

Provider Name: _____ Provider Tax ID#:_____
Claim Number: _____ Date(s) of Service: _____
Member Name: _____ Member ID# _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

**REASON FOR DISPUTE (PLEASE CHECK):**

☐ Claim was denied for no authorization, but authorization #_____ was obtained.
☐ Claim was denied for no authorization, but no authorization is required for this service.
☐ Claim was denied for untimely filing in error (proof of timely filing should be attached).
☐ Claim was paid to wrong provider
☐ Claim was paid for incorrect amount
☐ Other (please explain below) _____
_____
_____

Date of Request: _____ Request Name: _____
Requestor Phone Number: _____

**ATTACH:** A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled along with the response to your original request for reconsideration.

**NOTE:** If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the provider manual. Please do not include this form with a corrected claim.

**MAIL** completed form(s) and attachments to:

Michigan Complete Health
PO Box 3060
Farmington, MO 63640-3060

**IMPORTANT NOTICE:** Michigan Complete Health will make reasonable efforts to resolve this request within 45 calendar days of receipt. That resolution may be:

1.Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you an EOP or letter to that effect.