CLAIM PAYMENT DISPUTE FORM

This form is to be used for:

- Out-of-network providers who wish to dispute the payment amount on a previously processed claim

Instructions for submission:

- Submit your request within 180 days of the date on your Explanation of Payment (EOP);
- Submit this form with ALL fields completed to:
  - Alliant Health Plans, PO Box 1247, Dalton, GA 30722 by mail; or
  - CustomerService@AlliantPlans.com by email; or
  - (866) 634-8917 by fax.
- Submit a separate form for each claim payment you wish to dispute

Provider Information

Request Date: _____

Provider Type:

- ☐ Physician
- ☐ Hospital/Facility
- ☐ Other health care professional

Provider Name: _____ NPI: _____

Group/Facility Name: _____ Tax ID: _____

Phone Number: _____ Fax Number: _____

Service Location: _____

Correspondence Address: _____

Contact Name: _____ Email: _____

Claim & Member Information

Claim Number: _____ Date of Service: _____

Member Name: _____ Member ID: _____

Member Address: _____

Total Billed Charges: _____

Reason for Dispute:

- ☐ Bundling Issue
- ☐ Payment Rate
- ☐ Other (Provide explanation in Comments)

Additional Information

Include the following documentation with your request for reconsideration:

- ☐ A statement explaining the basis for the dispute
- ☐ A copy of the original claim
- ☐ A copy of the original EOP
- ☐ Any additional records, including clinical information, to support the dispute

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Comments

Describe the proposed resolution to the dispute, including but not limited to the specific action and payment* amount requested.

*Claim payments are subject to benefit determination and member cost share requirements.

Alliant Health Plans has 45 calendar days from receipt to respond to claim payment disputes. If you have questions, please call Alliant Customer Service at (800) 811-4793.