AMERICAN HEALTH ADVANTAGE OF MISSISSIPPI

PROVIDER DISPUTE RESOLUTION REQUEST

- Please complete the below form. 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. Mail the completed form, along with any required supporting documentation to:

American Health Plan of Mississippi
201 Jordan Road, Suite 200
Franklin, TN 37067
Toll-free: 1-844-917-0642
Or Fax to 1-844-280-5360

*Provider NPI:	*Provider Tax ID:
*Provider Name:	Contracted: ☐ Yes ☐No
*Provider Address:	
Provider Type: ☐ SNF ☐ Hospital ☐ Ambulance ☐ DME ☐ Rehab ☐ Other(Please specify): _____	
CLAIM INFORMATION: ☐ Single ☐ Multiple (please provide listing) Number of Claims: _____	
*Patient Name:	
*Health Plan ID Number:	Claim Number:
* Date of Service:	Original Claim Amount Billed:
DISPUTE TYPE: ☐ Claim Denial ☐ Disputing Request for Reimbursement of Overpayment ☐ Disputing Underpayment of Claim Paid ☐ Other: _____	
*DESCRIPTION OF DISPUTE:	
EXPECTED OUTCOME:	
Contact Name:	Title:
Signature:	Date:
Phone#:	Fax #:

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

Note: **Non-Par Providers have 60 days from denial date to file appeal for post service claims.**
Par Providers have 180 days from date of Explanation of Payment (EOP) to file a dispute resolution request.