Arizona Complete Health–Complete Care Plan
Attention: Provider Claim Disputes
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281-5713

PROVIDER CLAIM DISPUTE FORM

INSTRUCTIONS

- 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. Do not include a copy of a claim that was previously processed
- For routine follow-up, please use the Provider Inquiry Request Form instead of this form

Mail the completed form to the following address, which is specific to AzCH disputes.

Arizona Complete Health–Complete Care Plan
Attention: Provider Claim Disputes
1850 W. Rio Salado Parkway, Suite 211, Tempe, AZ 85281-5713

For provider dispute inquiries or filing information, contact us at the telephone number listed above.

***PROVIDER NAME:**	***PROVIDER TAX ID #:**
PROVIDER ADDRESS:	**Contracting: Y / N (circle)** ☐ ☐

PROVIDER TYPE: Physician   Mental health   Hospital   ASC/outpatient services   SNF   DME   Rehab   Home health   Ambulance   Other: ______________________________

***CLAIM INFORMATION**   Single   Multiple "**LIKE**" claims (complete attached spreadsheet) Number of claims: ______

***Member Name:**		**Date of Birth:**
***Social Security Number:**	***AHCCCS ID:**	***Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
***Service "From/To" Date:**	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE: Dispute of Medical Necessity/Utilization Management Decision   Contract Dispute   Seeking Resolution of a Billing Determination   Disputing a Request for Reimbursement of Overpayment   Other

***DESCRIPTION OF DISPUTE:** **INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND BASIS** (Additional paper can be attached if necessary)

***EXPECTED OUTCOME:** **PLEASE PROVIDE BY CLAIM, IF MULTIPLE**

Contact Name (please print)	**Title**	( ) **Telephone # (w/area code)**
Signature and date	**Email address**	( ) **Fax # (w/area code)**

[ ] ***CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:***
(Please do not staple information)

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For Health Plan Use Only
Case # ________________
Provider # _______________

PROVIDER CLAIM DISPUTE

INSTRUCTIONS: (For use with multiple "like" claims only)

- 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
  Do not include a copy of a claim that was previously processed
- For routine follow-up, please use the Provider Inquiry Request Form instead of the Provider Dispute Resolution Form

Mail the completed form to the following address.

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Attention: Provider Claim Disputes
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Tempe, AZ 85281-5713

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Number	*Patient Name		Date of Birth	*Member ID No./ AHCCCS Number	*Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	*Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

[ ] ***CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:***
(Please do not staple information)

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For Health Plan Use Only

Case # __________________

Provider #__________________