Care1st Health Plan Arizona
Attention: Provider Claim Disputes
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281-5713

PROVIDER STATE FAIR HEARING REQUEST

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.

Mail the completed form to the following addresses.Please note the specific address for all Care1st Arizona disputes.

Care1st Health Plan Arizona
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 (866)560-4042, Option 5

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

PROVIDER TYPE: ☐ Physician ☐ Mental Health ☐ Hospital ☐ ASC/ Outpatient Services ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other Professional (please specify type of "other")__________________

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

***Patient 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: ☐ Claim ☐ Appeal 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 RATIONALE** (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 STATE FAIR HEARING REQUEST

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

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For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

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:***
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For Health Plan Use Only

Case # ________________

Provider #________________