Care1st Health Plan Arizona
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
- Mail the completed form to the following address, which is specific to Care1st Arizona disputes.

  Care1st Health PlanArizona
  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 (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)

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.

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

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)

For Health Plan Use Only

Case # _____

Provider #_____