| *Targeted Rate Increase* (TRI)

PAYMENT DISPUTE REQUEST

Instructions
* Please complete ***ALL FIELDS*** of the below form. * Be specific when completing the OTHER COMMENT. * Attached additional information to support the description of the dispute, if necessary. * Please EMAIL this completed form to TargetedRateIncrease@iehp.org. * IEHP will respond within 30 working days upon receipt of this dispute request.

Billing Provider Information	
Billing Provider Name:	
Billing Provider TaxID:	
Billing Provider Address:	
Billing Provider Email:	
Billing Provider Phone #:	

Disputed Claim(s) Contract Type	
Capitation Fee-For-Service (FFS)	
Case Rate	
Fee-For-Service (FFS)	

Capitation or Case Rate - *If the provider contract type of the service being disputed is Capitation or Case Rate, please provide details about the dispute below:*

| Targeted Rate Increase (TRI)

FFS Disputes
If the provider contract type of the service being disputed is FFS, please fill out the table below:

Claim/Encounter Information

IPA Name/ IEHP Direct	Claim/ Encounter Number	Line #	Procedure Code	Member ID	Service Date	Original Claim Amount Paid	Rendering Physician Name	Rendering Physician NPI

Dispute Type

- ☐ Nonpayment
- ☐ Underpayment
- ☐ Incorrect payment information (e.g. TaxID, address, vendor name, etc.)

OTHER COMMENTS:

Contact Name (Please print)

Title

Signature

Date