

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	t Type
Capitation	
Case Rate	
Fee-For-Service (FFS)	
Rate, please provide details	f the provider contract type of the service being disputed is Capitation or Case about the dispute below:



FFS Dispute	

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

Dis	ispute Type	
□ Nonpayment		
□ Underpayment		
□ Incorrect payment information (e.g. TaxID, address other COMMENTS:	ress, vendor name, etc.)	
OTHER COMMENTS:		
Contact Name (Please print)	Title	
		
Signatura	Data	
Signature	Date	