

PROVIDER DISPUTE RESOLUTION REQUEST (For use with multiple "LIKE" claims)

	* Patient Name		*Date of Birth	*Health Plan ID Number	Claim ID Number	*Service From/To Date	Claim Amount Billed	Claim Amount Paid	Expected Reimbursement Amount	Comments
	Last	First								
1										
2										
3										
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11										
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CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

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