

CLAIM DISPUTE COVER LETTER

Use this form as part of the Oklahoma Complete Health request for formal reconsideration or appeal for re-evaluation or exception to a plan policy or contract requirement such as medical necessity, benefit limitations, eligibility, failure to obtain authorization or timely filing. This form must be filled out in full and sent in with the request.

Name/ Address of person submitting appeal:	Date:
Click or tap here to enter text.	Click or tap here to enter text.
Provider Name:	Provider Tax ID Number:
Click or tap here to enter text.	Click or tap here to enter text.
Control/claim Number:	Date(s) of service:
Click or tap here to enter text.	Click or tap here to enter text.
Member Name:	Member ID Number:
Click or tap here to enter text.	Click or tap here to enter text.

Reason for Request:

□ Claim was denied for untimely filing error (attach proof of timely filing)

□ Claim was denied for global/ unbundled procedure (attach medical records)

 \Box Claim was paid incorrectly based on expected reimbursement or contracted rates

□ Claim was denied for no authorization, but authorization # ______ was obtained

□ Claim was denied for no authorization, but no authorization is required for this service

 \Box The authorization on file was denied for medical necessity (attach appeal letter and medical records)

□ Claim was denied for benefit limitations

 \Box Other (please explain):

Mail or fax completed form and attachments to: Oklahoma Complete Health Appeals Department P.O. Box 8060 Farmington, MO 63640-8060

Fax: (833) 951-1150