



Provider Dispute Resolution Request

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing the Description of Dispute and Expected Outcome sections.
- Fax the completed form, along with any required supporting documentation, to 1-844-280-5360; OR Mail to:

American Health Advantage of Texas
201 Jordan Road
Franklin, TN 37067

*Provider NPI:		*Provider Tax ID:	
*Provider Name:		Contracted: ☐ Yes ☐ No	
*Provider Address:			
Provider Type: ☐ Skilled Nursing Facility (SNF) ☐ Hospital ☐ Ambulance ☐ DME ☐ Rehab ☐ Other (Please Specify): _____			
Claim Information: ☐ Single ☐ Multiple (Please Provide Listing) Number of Claims: _____			
*Patient Name:			
*Health Plan ID Number:		Claim Number:	
*Date of Service:		Original Claim Amount Billed:	
Dispute Type: ☐ Claim Denial ☐ Disputing Request for Reimbursement of Overpayment ☐ Disputing Underpayment of Claim Paid ☐ Other (Please Specify): _____			
*Description of Dispute:			
Expected Outcome:			
Contact Name:		Title:	
Signature:		Date:	
Phone Number:		Fax Number:	

☐ Mark here if additional information is attached. Please do not staple.