AMERICAN HEALTH ADVANTAGE OF TEXAS

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) ☐ Ambulance ☐ Rehab	☐ Hospital ☐ DME ☐ 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.

Note: Non-Par Providers have 65 days from denial date to file appeal for post service claims. Par Providers have 180 days from date of Explanation of Payment (EOP) to file a dispute resolution request.