



PROVIDER PAYMENT DISPUTE FORM

This form is for providers disputing a claim with ApexHealth. For additional information and requirements regarding provider claims disputes, please refer to the ApexHealth Provider Manual at www.apexhealth.com/providers/. Please note, this form is for claim payment disputes related to reimbursement rate or processing. This form is NOT intended for requests related to clinical reviews for medical necessity determinations in the case of a denied authorization or retrospective review request.

DO NOT use this Provider Payment Dispute form to submit an appeal on behalf of a member for a denied authorization before rendering service.

Send corrected claims as normal claim submissions electronically. This includes claims with primary payer information and Explanation of Payment (EOP). Any corrected claims received as appeals will NOT be processed.

A SEPARATE FORM MUST BE SUBMITTED FOR EACH MEMBER

MEMBER INFORMATION

Member ID Number	Member Name	Member DOB

PROVIDER INFORMATION

Group/Practice Provider Name	Tax ID	Group Provider NPI
Rendering Provider Name	Rendering Provider NPI	
Office Contact	Contact Phone Number	Contact Fax Number
Contact Mailing Address		

CLAIM INFORMATION

Claim Number(s)	Date of Service	Billed Amount
Date of Determination Letter		

REASON FOR CLAIM RECONSIDERATION / PAYMENT DISPUTE

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided on the ApexHealth determination letter or Explanation of Payment. Please attach all supporting documentation. Based upon the following reason(s), Provider requests reconsideration of this claim:

- | | | |
|---|--|---|
| <input type="checkbox"/> Exceeded timely filing | <input type="checkbox"/> Claim code editing denial | <input type="checkbox"/> Denied as duplicate |
| <input type="checkbox"/> No authorization | <input type="checkbox"/> Denial related to provider data issue | <input type="checkbox"/> Denied for Other Health Insurance but member doesn't have Other Health Insurance |
| <input type="checkbox"/> Payment Amount Dispute | <input type="checkbox"/> Member retro-eligibility issue | <input type="checkbox"/> Data elements on the claim on file does not match the claim originally submitted |
| <input type="checkbox"/> Other (Please Describe): | | |

A **payment dispute** is a request from a health care provider to change a decision made by ApexHealth related to claim payment for services already provided. A provider payment dispute is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

Non-PAR Provider Appeal: A non-contracted Provider, on his or her own behalf, may request a reconsideration for a denied claim only if the non-contract provider completes a Waiver of Liability (WOL) statement, which provides that the non-contracted Provider will not bill the enrollee regardless of the outcome of the appeal.

Please return this completed form and all supporting documentation to:

Email: appeals@apexhealth.com

Fax: (313)-591-1155

Mail: ApexHealth ATTN: Provider Appeals
96 Kercheval Avenue, Suite 200
Grosse Pointe Farms, MI 48236