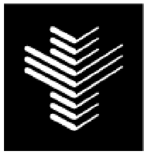


Provider Dispute Request Process and Form

PLEASE READ CAREFULLY AND FOLLOW THE INSTRUCTIONS INDICATED

A **DISPUTE REQUEST** is defined as a **claim** that prevents Parkland Community Health Plan (PCHP) from processing it due to any of the following reason(s)**:**

1. Originally denied because of incorrect coding (would be a considered a "Corrected Claim"); or
2. Missing information (would be considered a "Reconsideration").

Corrected Claim Instructions

Submit a corrected claim and mark on top of it, "CORRECTED CLAIM FOR RECONSIDERATION" along with a completed *Provider Dispute Request Form*, provided on page 4.

Examples of a Corrected Claim
• Newly added modifier
• Code changes
• Any change to the original claim

Reconsideration Instructions

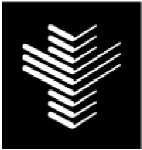
1. Submit **a claim form** and mark on top of it, "RECONSIDERATION" along with a completed *Provider Dispute Request Form*, provided on page 4.
2. Submit medical records and/or additional information required to reconsider the claim. Information should be submitted single sided.

Examples of Reconsiderations
Itemized Bill: • All claims associated with an Itemized Bill must be broken out per revenue codes to verify charges billed on a UB or HCFA claim form match the charges billed on the Itemized Bill. (Please attach I-Bill that is broken out by rev code with sub-totals.)
Duplicate Claim: • Review request for a claim with an original reason for denial as "duplicate" • Provide documentation as to why the denied claim or service is not a duplicate, such as medical records showing two services were performed
Late/No Authorization: • Review request for a claim with a denial reason for no authorization or requesting the authorization past the allowed timeframe

Examples of Reconsiderations
• Medical records submitted with a claim or for a claim that has already been denied will be considered as a "Reconsideration" request
New Texas Provider Identifier (TPI) Issues or Re-attestation: • Review request for a claim with a denial reason for a TPI issue or re-attestation • Provide a copy of the attestation notification indicating the date of the attestation
Coordination of Benefits (COB): • Review request for a claim with a denial reason for COB information • Attach an EOB or letter from the primary carrier along with the denied claim and/or EOB

ALL CLAIM DISPUTES (Corrected Claims and Reconsiderations)

Must Be Submitted To (Claims Mailbox): **Parkland Community Health Plan**
PO Box 560327
Dallas, TX 75356



Provider Dispute Request Form

Please complete the information below in its entirety and mail with supporting documentation to the claims dispute address:

Parkland Community Health Plan
PO Box 560327
Dallas, TX 75356

Questions regarding a submission should be directed to the Provider Services call center at:

Health*first* (STAR):	**Kids*first* (CHIP):**	**CHIP Perinate:**
1-888-672-2277	1-888-814-2352	1-888-814-2352

Please indicate the reason for your request and any pertinent details below:

TYPE OF ISSUE/DISPUTE: ☐ **Corrected Claim** ☐ **Reconsideration**

Plan Type: ☐ HEALTH*first* ☐ KIDS*first* ☐ CHIP Perinate ☐ N/A

Provider Name:	
Submitter's name:	
Provider Phone Number:	
Date(s) of Service:	
Remittance Advice Date:	
Amount Billed:	
Amount Paid:	
Claim Number(s):	
Member Name:	
Member ID #:	

____ ____________________
Signature of Sender Date

DISCLAIMER: Providers should always refer to the PCHP Provider Manual and their contract for further details. For general claims inquiry, please contact the toll-free number located on the member's ID card, 8:00 am – 5:00 pm (CST) Monday to Friday. You may also contact this number for more information on the Claims Inquiry process. Be prepared to provide the Provider Relations Representative with the Provider Name and Provider ID, Member Name and ID, Date(s) of Service, and Claim Number from the Remit Notice.