Advantage MD Participating Provider
Post-Service Payment Dispute Form

This form should be completed within 90 days of notification of denial (remittance). Submit one form unique to the member. Send this form with supporting documentation, to: **Johns Hopkins Advantage MD Payment Disputes, P.O. Box 3537, Scranton, PA 18505. FAX 855-206-9206.**

This form should be completed by Participating Providers Only.

Date of Submission: _____

Provider Information	
Provider/Facility Name:	
Dispute Response Contact Name:	
NPI #:	Tax ID:
Telephone:	Fax:
Member (Patient) Information (One Member Only)	
First Name:	Last Name:
ID #:	Date of Birth:
Service Provided	
Date of Service(s):	Claim Number(s)/ ICN(s):
Authorization # (if applicable):	
Claims Dispute Reason	**Clinical Dispute Reason**
☐ Overpaid/Underpaid Per Contracted Rate	☐ **Clinical Review for Medical Necessity**. Cases that require a licensed professional to make a determination against national criteria or JHHC policy. Days that were approved on concurrent review **will not** be reviewed for change in level of care. (Must include complete medical record.) ☐ **Administrative Denial.** Examples include no authorization obtained. (Must include documentation of extenuating circumstances to be reviewed and complete medical record.)

Notes:

For more detailed information on payment dispute processes and policies please reference your JH Advantage MD Provider Manual.