Provider Claims/Payment Disputes and Correspondence Submission Form

FOR EHP, PRIORITY PARTNERS AND USFHP PARTICIPATING PROVIDERS USE ONLY

This form is for participating providers for claim/payment disputes and claim correspondence only. Please submit one form for each claim/payment dispute reason.
Note: This form is **not** to be used for clinical appeal requests—it is for payment disputes only.

Date of Submission: _____

Please select Health Plan	
☐ EHP ☐ Priority Partners ☐ USFHP	
Provider/Appellant Information	
Provider/Facility Name:	
NPI #:	Tax ID #:
Phone #:	Fax #:
Member (Patient) Information	
First Name:	Last Name:
ID #:	Date of Birth:
Service Provided	
Date(s) of Service :	Claim(s) #: ***If multiple claims, attach all claim numbers** Total Number of Claims: Total Amount Billed:
Claims Disputes Reason	
☐ Duplicate Claim (need proof of non-duplication) ☐ Rejected Untimely Filing of a Claim (attach proof of timely filing) ☐ Itemized Bill Requested (please attach itemized bill) ☐ COB/OIC Issues (need primary carrier EOB) ☐ Eligibility Issues ☐ Invoice Attached/MUE Denial	☐ Fee Schedule ☐ Over/Under Payment (provide justification) ☐ Referral Attached (provide paper referral) ☐ Contract Rate/Single Case Agreement ☐ Authorization on File (need authorization #) ☐ Out of State Rates ☐ IP Bed Level Issues ☐ Other (must have comments attached)
Notes/Comments:	

Send this form with all supporting documentation to:
Johns Hopkins Health Plans Attn: Adjustments Department
7231 Parkway Dr, Ste.100 Hanover, MD 21076 or Fax: 410-424-2800

For more detailed information on claims/payment dispute policies and procedures, please reference the Provider Manual for the appropriate health plan or your Provider Participation Agreement.