univera HEALTHCARE
an excellus company

Ambulatory Payment Classification Pricing Dispute Form

Please submit this form with each individual claim request, **accompanied by a copy of your claim submittal.** Multiple claim requests (with the same reason for dispute) may be submitted on a single form if you use a spreadsheet, but the spreadsheet must include the claim-specific information required below, **as well as a detailed pricing expectation sheet for each line item on the claim** identified on the spreadsheet. **Forms should be completed with black ink** to ensure readability after faxing.

Please do not submit balances that are the patient's responsibility (deductible, coinsurance or penalty amount applied).

Date Request Submitted: _____

Hospital Name: _____Provider ID #: _____

Contact Name: _____ Phone #: _____Fax#_____

Patient Name: _____

Patient ID# (including prefix): _____

Patient Account #: _____Date(s) of Service (From/To): _____

Claim # to be Reviewed: _____

Date Paid: _____

Reason for Review: Please provide a detailed description below

- ☐ Questioning APC code(s) paid
- ☐ Questioning APC payment
- ☐ Questioning payment for status indicator (please specify)
- ☐ Questioning multiple surgery payment
- ☐ Questioning composite pricing
- ☐ Questioning lab (lab panel) pricing
- ☐ First level dispute (select if you do not agree with original findings)
- ☐ Second level dispute (select if you do not agree with first level dispute findings)
- ☐ Other (please specify)

Description_____

_____

Fax completed form and supporting documentation to:
Univera Healthcare Innovative Provider Solutions
Fax: 1-800-244-0195