univera HEALTHCARE
an excellus company

Ambulatory Patient Group Pricing Dispute Form

Submit this form with each individual claim request, along with 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 Number (include prefix):_____

Patient Account Number: _____ Date(s) of Service (From/To): _____

Claim Number to be Reviewed: _____ Date Paid: _____

Reason for Review: Please provide a detailed description below.

- ☐ Questioning APG code(s) paid
- ☐ Questioning APG payment
- ☐ Questioning APG denial
- ☐ 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 this completed form and supporting documentation to:

Univera Healthcare Client and Provider Services

Fax: 1-800-244-0195