PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

Note: Submission of this form constitutes agreement not to bill the patient

Number	*Patient Name		Date of Birth	*Health Plan ID Number	Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

[ ] Check here if additional information is attached
(Please do not staple additional information)