Claims Dispute Form

Please note! This form is not required for most claim adjustment, correction, replacement, or void requests. For example, if you want to change or add a code, billing amount, unit count, or modifier, simply send us another claim with the corrected information and the Martin's Point claim number from the claim that is being adjusted or corrected. Electronic submission is preferred. Visit **https://forproviders.martinspoint.org/resources/claims** *for more information.*

If your claim dispute falls into one of the categories listed below, you may complete this form.

All fields are required. **Be sure to include the Martin's Point CLAIM NUMBER from the claim that you would like to dispute. DO NOT include a copy of the claim with your dispute request.** Claim disputes may be submitted only after the original claim has been paid or denied and must be submitted within 120 days of the remittance date.

Member Name:	Member ID #:
Date of Service:	Martin's Point Claim #:
Previous Authorization #:	
Provider Name:	Provider NPI #:
Contact Person:	Contact Phone #:
Contact Mailing Address:	

Please select the reason for your claim dispute and explain the issue in the comments section below.

Prior Authorization Edit: The provider is requesting to make a change to an authorized service/procedure (e.g. add a code, date change, etc.). Supporting clinical documentation is required.

Code Review: Supporting clinical documentation is required.

Contract Term(s): The provider believes the previous claim was not paid in accordance with negotiated terms. Supporting documentation is required.

Coordination of Benefits: The original claim could not be processed completely until information from another insurer was received.

Duplicate Claim: The original denial was due to a duplicate claim submission. Supporting documentation is required.

Filing Limit: The original claim was denied for untimely filing. Supporting documentation is required.

Request for Additional Information: The original claim was denied due to missing or incomplete information.

Retraction of Payment: The provider is requesting a retraction of an **ENTIRE** payment (e.g., wrong provider paid, incorrect provider information, patient not on provider panel, service not performed, etc.).

Comments:

Please submit this form to: Martin's Point Health Care, Claims Department, PO Box 11410, Portland, ME 04104-7410.

Questions? Please visit **https://forproviders.martinspoint.org/resources/claims**