Provider Claims Dispute Form

Martin's Point

Complete all information. Incomplete submissions will be returned unprocessed.
Do not include a copy of the claim with your dispute request.

Provider Information

Provider Name:	Contact Name:
National Provider Identifier (NPI):	Contact Phone Number:
Contact Fax Number:	Contact Email Address:
Contact Address:	

Member Information

Martin's Point Health Plan: ☐ **US Family Health Plan** ☐ **Generations Advantage**	
Member ID:	Member Name:
Date(s) of Service (MM/DD/YY):	
Claim Number(s) (Multiple claims may be listed if disputing the same denial reason for all claims. For more than two claims, please mail a spreadsheet or list of additional claims with this completed form.):	

Review Type

See review type descriptions/examples in the Provider Claims Dispute Overview available at martinspoint.org/ProviderClaimsDispute and select the one that best applies. Check the appropriate box and provide any clarifying details in the comments section if needed.

☐ **Code Review:** For denials based on improperly coded services.

☐ **Denied Authorizations:** For denials due to invalid or denied prior authorization request for the service or date(s) of service.

☐ **Failure to Obtain Authorization Due to Emergency and Urgently Needed Services (Generations Advantage only):** For denials due to missing authorization arising from emergency and urgently needed services, as set forth in 42 CFR § 422.113.

☐ **Coordination of Benefits Review:** For denials due to coordination of benefits issues, such as missing or incomplete primary EOB or conflicts with other health insurance coverage.

☐ **Timely Filing Review:** For denials due to submission outside of timely filing window. This may happen if the original claim wasn't received, a denial was issued for a previously submitted claim, or a delay occurred due to coordination.

☐ **Benefit Limitations or Non-Covered Services:** For denials resulting from plan coverage rules, such as services that are excluded from benefits or that exceed defined benefit limits.

☐ **Contractual or Pricing Review:** For payment amounts that may not match provider agreement, or incorrect takeback/recoupments.

☐ **Duplicate Review:** For denials incorrectly identified as duplicate submissions.

☐ **Other:** Use for disputes that don't fall into any categories above and may need special handling or clarification.

Comments:

Provider claims disputes **must be submitted by mail** to the Claims Department at PO Box 11410, Portland, ME 04104. Disputes are not accepted via phone or eFax at this time.