Provider Payment Dispute Request

IMPORTANT INSTRUCTIONS TO FACILITATE QUICK RESOLUTION

- This form can be used for both Davis Vision and Superior Vision
- Complete the form fields. Fields with an asterisk (*) are required. Forms with incomplete fields could delay processing.
- Complete this form if you are seeking reconsideration of a previous billing determination.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME
- Provide additional information to support the description of the dispute. Do not include a claim that was previously processed.
- To ensure the integrity of the Provider Payment Dispute Resolution process, we will re-categorize issues sent to us on a Provider Payment Dispute Resolution form, which are not true provider disputes (e.g., claims check tracers or a provider's submission of medical records after payment was denied due to a lack of documentation).
- If someone other than the Provider is completing this form, the information completed must be specific to the provider who is disputing a payment determination and not to the person completing the form.
- Submit this form to:

  Mail: Versant Health
  Complaints and Appeals Department
  PO Box 791
  Latham, NY 12110
  Fax: 1-888-778-1008
  Email: ProviderCA@versanthealth.com

- The Provider Payment Dispute Resolution process is detailed in your Provider Manual located in the Versant Health Provider Resource Center at **http://prc.versanthealth.com**

Payment Dispute Type

☐No authorization on file

☐No prior authorization on file (service required a medical necessity review and approval)

☐Benefit Administration (Member not eligible on the date of service, service is not a covered benefit)

☐ Contract Reimbursement (payment received is not in alignment with the contracted rate)

☐ Contract Status (In Network Provider denied for being out of network)

☐ CPT/Diagnosis Code Combination Issue (the services provided are not identified as being reimbursable/or the services provided are not covered for either the member's routine or medical benefit)

☐Other: (Please provide specific information regarding your payment dispute)

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VersantHealth™

***Provider Name**	***Provider ID or Number:**
Provider Office Name	
***Provider Address**	
***Provider Type:** ☐MD ☐OD	
***Contracted Provider** Yes ☐ No ☐	
***Claim Information** *Claim #:	
***Date of Service**:	
***Services Denied:**	
Original Claim Amount Billed:	
Original Claim Amount Paid:	
***Denial Reason(s) code(s):**	
***Description of Dispute:**	
Expected Outcome:	
***Member/Patient Information** First Name Last Name DOB	
Patient/Member Health Plan Insurer	
Patient/Member Identification #	

Provider Payment Dispute Request

Contact Name (please print)	Title	Phone Number
Signature of Person Completing the Form	Date	Fax Number

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**