Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Anthem BlueCross BlueShield

Provider Dispute Resolution Request Form

Submission of this form constitutes agreement not to bill the patient during the dispute process.

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when providing the description of dispute and expected outcome.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the *Claims Follow-Up Form*.

Mail the completed form to: **Anthem Indiana**
Provider Disputes and Appeals
P.O. Box 61599
Virginia Beach, VA 23466

Provider name*: _____

NPI number: _____ Rendering provider NPI number: _____

TIN: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Provider type: ☐ MD ☐ Ambulatory surgery center ☐ Ambulance ☐ Hospital
☐ Skill nursing facility ☐ Durable medical equipment ☐ Rehab ☐ Home health
☐ Mental health ☐ Other: _____

Claim information

☐ Single ☐ Substantially similar multiple claims (Complete page 2.)

Patient name*: _____ Date of birth: _____

Health plan ID number*: _____ Patient account number: _____

Original claim ID number (If multiple claims, complete page 2.): _____

Service of from/to dates* (required for claim, billing and reimbursement of overpayment disputes):
_____/_____

Original claim amount billed: _____ Original claim amount paid: _____

Dispute type

☐ Claim ☐ Seeking resolution of a billing determination ☐ Contract dispute
☐ Request for reimbursement of overpayment ☐ Appeal of medical necessity/utilization management decision
☐ Other (please specify): _____

Description of dispute*: _____

_____

_____

Expected outcome: _____

Contact name (please print): _____ Title: _____

Phone number: _____ Fax number: _____

Signature: _____ Date: _____

☐ **Check here if medical records are attached. Please do not staple medical records to this form.**
☐ **Check here if additional information is attached. Please do not staple additional information.**

For health plan use only: Tracking number: _____ Provider ID: _____

www.anthem.com/inmedicaiddoc

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Use this page only for multiple like claims (disputed for the same reason). Fields with an asterisk (*) are required.

Provider name*: _____
NPI number: _____ Rendering provider NPI number: _____
TIN: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

1. Patient name* (last, first): _____
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: _____

2. Patient name* (last, first): _____
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: _____

3. Patient name* (last, first): _____
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: _____

4. Patient name* (last, first): _____
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: _____

5. Patient name* (last, first): _____
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: _____

☐ **Check here if medical records are attached.** Please do not staple medical records to this form.
☐ **Check here if additional information is attached.** Please do not staple additional information.