



PROVIDER CLAIM DISPUTE FORM

Use this form as part of the Magnolia Health Plan of Mississippi Claim Dispute process to dispute the decision made during the request for reconsideration process.

NOTE: Prior to submitting a Claim Dispute, the provider must first submit a "Request for Reconsideration". The Claim Dispute must be submitted within 45 calendar days of the date on the determination letter or EOP from your original request for reconsideration.

All fields in the box immediately below are required information

Provider Name	Provider Tax ID#
Control Number <i>Located EOP Under Patient Name</i>	Date(s) of Service
Member Name	Member (RID) Number

Reason for Dispute (please check):

- Claim was denied for no authorization, but authorization # _____ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for untimely filing in error (proof of timely filing should be attached).
- Claim was paid to wrong provider
- Claim was paid for incorrect amount
- Other (please explain below) _____

Date of Request: _____ Requestor Name: _____

Requestor Phone Number: _____

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled along with the response to your original request for reconsideration.

NOTE: If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the provider manual. Please do not include this form with a corrected claim.

Mail completed form(s) and attachments to:

Magnolia Health Plan
PO Box 3000
Farmington, MO 63640-3800

Important Notice: Magnolia Health Plan will make reasonable efforts to resolve this request within 45 calendar days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you an EOP or letter to that effect.