PROVIDER DISPUTE FORM

Use this form as part of Sunshine Health’s Provider Claims Inquiry process to request adjustment of claim payment received that does not correspond with payment expected.

NOTE: Adjustment Requests must be submitted within 90 calendar days of the original determination or Explanation of Payment (EOP) for reconsideration.

All fields in the box immediately below are required information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Tax ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Number</td>
<td>Date(s) of Service</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member (RID) Number</td>
</tr>
</tbody>
</table>

Reason for Adjustment Request (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: __________________________

NOTE: If original claim submitted requires a correction, such as a valid procedure code, location code or modifier, include a copy of that page from your EOP with the claim circled, along with a copy of the new, corrected CMS-1500 or UB-04 form, marked “Corrected Claim” across the top.

Mail completed form(s) and attachments to:

**For Medical Claims:**
Sunshine Health
P.O. Box 3070 (Medicaid)
P.O. Box 3060 (Ambetter and Allwell)
Farmington, MO 63640-3823

**For Behavioral Claims:**
Sunshine Health
P.O. Box 6900
Farmington, MO 63640-3818

Attach a copy of the EOP(s) with Claim(s) to be adjudicated clearly circled with the response to your original request for reconsideration.

Important Notice: Sunshine Health Claims Office will make reasonable efforts to resolve this request within 30 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 a letter to that effect.

This Adjustment Request form does not initiate an Informal Claim Dispute / Objection and does not push back the deadline to file a written informal Dispute / Objection, which is Step 1 of an official appeal and must be filed within 45 calendar days of original decision shown on your EOP. For more information, see Sunshine Health’s Provider Manual.

(This form may be photocopied)