PROVIDER DISPUTE FORM

Use this form as part of Sunshine Health's Provider Dispute process to request review of claim and non-claim matters.

NOTE: Non-Claim disputes must be submitted 45 calendar days from the original date the issue(s) occurred. Claim disputes must be submitted 90 calendar days from the final determination or Explanation of Payment (EOP) determination. Disputes will not be considered formal disputes if not received within these timeframes.

All fields in the box immediately below are required information

Provider Name	Provider Tax ID#
Control Number	Date(s) of Service
Member Name	Member (RID) Number

Reason for Dispute (please check):

❑ Claim Dispute

❑ Non-Claim Dispute

Please explain below:

_____

_____

_____

_____

_____

Date of Request_____ Name of Requestor_____

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. Use the Provider Claim Adjustment Request Form to request adjustment of claim payment received that does not correspond with payment expected.

Mail completed form(s) and attachments to:

Sunshine Health
Post Office Box 3070
Farmington, MO 63640-3823

Or fax to 1-833-504-0580