

Provider Payment Integrity (PPI)

Medical Record Review Dispute Request Form

Please complete and attach this form to your formal letter of dispute to ensure your documentation is routed appropriately. Be sure to include the original Medical Record Review Initial Findings Letter and any other documentation that supports your dispute. Fax materials to 888-815-8912 or mail to:

Humana Provider Payment Integrity Disputes

P.O. Box 14279

Lexington, KY 40512-4279

Healthcare provider’s name:
State of practice: \_\_\_\_\_\_\_\_\_\_
Healthcare provider’s address:

|  |
| --- |
| 1. Please indicate the type of dispute: Review findings Claim payment  If this is a payment dispute, please note the amount being disputed: $\_\_\_\_\_\_\_\_\_\_ Has this amount been previously disputed? Yes No |
| 2. What Humana claim number do you wish to dispute? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Note: If you wish to dispute multiple claims, please mail or fax them separately.  |
| 3. Is the disputed claim a corrected claim? Yes No  If yes, what is the original billed claim number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. What level of dispute is this (if applicable)? 1 2  |
| 5. What type of policy does this dispute involve? Medicaid Medicare Commercial  |
| 6. Are you a participating (contracted) or nonparticipating (noncontracted) healthcare professional? Participating Nonparticipating |
| 7. Patient’s name:  |
| 8. Patient’s account number: |
| 9. Humana ID number: |
| 10. Patient’s date of birth:  |
| 11. Date(s) of service on claim:  |