Claims Payment Review Request
For Contracted Providers

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

Please complete this form if you are seeking reconsideration of a previous billing determination. You can include a separate page if additional information is needed to support the dispute. Do not include a copy of a claim that was previously processed.

This form is to be completed by Memorial Hermann Health Plan contracted physicians, hospitals or other health care professionals to request claim reconsideration for members enrolled in commercial benefit plans administered by Memorial Hermann Health Plan and Memorial Hermann *Advantage* HMO and PPO plans.

Mail the completed form to:
Memorial Hermann Health Plan
Attn: Appeals and Grievances
929 Gessner Road, Suite 1500
Houston, TX 77024
Or you can fax to: 713.704.0884

Member Information:

Member ID:	Control/Claim #:	Date of Service:	Billed Amount:
Member Name (Last):		First:	MI:
Street Address:		State:	Zip:

Physician Information:

Tax Identification Number (TIN):	Phone Number:	
Physician Name (Last, First: as listed on Provider Remittance Advice - PRA):	Email address:	
Street Address:	State:	Zip:
Facility/Group Name:	Contact person:	

Reason for request:

☐ Previously denied/closed as "Exceeds Filing Time"

What should I submit as evidence of timely filing?
Electronic claims – include confirmation that Memorial Hermann Health Plan has received and accepted your claim.
Paper claims – include a screenshot to show the date you submitted the claim. Show the correct patient and the correct visit.
**Proof of timely filing could also include other insurance carrier's denial, EOB, letter indicating terminated coverage, etc.*

☐ Previously denied/closed for "Additional Information" (provide description and/or requested documents)
☐ Previously denied/closed for "Coordination of Benefits" information (attach primary carrier's EOB)
☐ Resubmission of a corrected claim denied duplicate in error (explain correction below)
☐ Previously processed but contracted rate applied incorrectly resulting in over/underpayment (explain below)
☐ Previously denied for NCCI coding edits/disagree with edit (ex: MUE, Add on, etc. Include notification information)
☐ Resubmission of "Bundled claim" (include all supporting information)
☐ Other (explain below)

***Please include what you are expecting from Memorial Hermann to close this claim in your practice management system.*

Contact Name (please print) _____ Title _____ ( ) Phone Number

Signature _____ Date _____ ( ) Fax Number

☐ *CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED*

Y0110_AG_Dispute17

For Health Plan Use Only
TRACKING NUMBER:
PROVIDER ID#:

PROVIDER DISPUTE RESOLUTION REQUEST

For use with multiple "LIKE" claims (disputed for the same reason)

Provider Name: Provider NPI#:

Number	Patient Name		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
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

☐ *CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED*
(Please do not staple additional information)

All PPO products are underwritten by Memorial Hermann Health Insurance Company. All HMO products are underwritten by Memorial Hermann Health Plan, Inc. This form is applicable to Memorial Hermann Health Solutions, Inc., Memorial Hermann Health Plan, Inc. and Memorial Hermann Health Insurance Company, all entities operating under the brand Memorial Hermann Health Plan.