PROVIDER DISPUTE RESOLUTION FORM

DATE(MM/DD/YYYY):_____

REQUESTER INFORMATION			
Provider Name			
Provider Tax ID #			
Contact Name		Signature:	
Telephone			
Fax			
Address			
City:		State:	Zip:

Claim Information (if applicable)			
Patient Name			
Patient ID#			
Claim Number			
Date(s) of Service		Process Date	
Billed Amount		Disputed Amount	

Reason for Dispute (please explain as detailed as possible)

Supporting Documentation

- ☐ Proof of Timely Filing
- ☐ Progress Notes
- ☐ Medical Records
- ☐ Delivery Tickets
- ☐ Original Claim Action Report
- ☐ Other:_____

Please submit this form to the Network Director at:

Coastal Care Services, Inc.

7875 NW 12 Street, Suite 200

Miami, FL 33126

Or

Email to ProviderRelations@ccsi.care