



### Provider Dispute Resolution Request Form

- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME fields. Provide additional information to support the description of the dispute and/or appeal. Do not include a copy of a claim that was previously processed.
- For Medicare non-contracted providers, please complete and include in your appeal a fully executed Waiver of Liability (WOL) Statement. If you complete a WOL Statement, you waive the right to collect payment from the member, with the exception of any applicable cost sharing, regardless of the determination made on the appeal. To appeal, mail your request and completed WOL Statement within 60 calendar days after the date of the Notice of Denial of Payment.
- Submit completed form(s) to Gold Kidney Health Plan.

**Mail:** Gold Kidney Health Plan  
 ATTN: Provider Dispute Resolution Department  
 P.O. Box 285, Portsmouth, NH 03802

**Fax:** (480) 716-7555

*Fields with an asterisk (\*) are required.*

<b>*Provider Name:</b>	<b>*Provider Tax ID# / Medicare ID#:</b>
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<b>Provider Address:</b>
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**Provider Type:**     MD     Mental Health     Hospital     ASC     SNF     DME     Rehab  
 Home Health     Ambulance     Other: \_\_\_\_\_

**\*Claim Information:**     Single     Multiple "LIKE" claims (complete attached spreadsheet) Number of claims: \_\_\_\_\_

<b>*Patient Name:</b>		<b>Date of Birth:</b>
<b>*Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> <small>(*If multiple claims, use attached spreadsheet)</small>
<b>Service From/To Date:</b> <small>(*Required for Claim, Billing, and Reimbursement of overpayment disputes)</small>	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>

**Dispute Type:**

<input type="checkbox"/> Claim A	<input type="checkbox"/> Seeking Resolution of a Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request for Reimbursement of Overpayment	<input type="checkbox"/> Other

**\*Description of Dispute:**

**Expected Outcome:**

_____	_____	_____
<b>Contact Name (print)</b>	<b>Title</b>	<b>Phone Number</b>

_____	_____	_____
<b>Signature</b>	<b>Date</b>	<b>Fax Number</b>

Check here if additional information is attached (*Please do not staple additional information*)