



Provider Dispute Resolution Request

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing the Description of Dispute and Expected Outcome sections.
- Fax the completed form, along with any required supporting documentation, to 1-844-280-5360; OR Mail to:

Kansas Health Advantage
201 Jordan Road
Franklin, TN 37067

*Provider NPI:	*Provider Tax ID:
*Provider Name: Contracted: <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Provider Address:	
Provider Type: <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Hospital <input type="checkbox"/> Ambulance <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Other (Please Specify): _____	
Claim Information: <input type="checkbox"/> Single <input type="checkbox"/> Multiple (Please Provide Listing)	
Number of Claims: _____	
*Patient Name:	
*Health Plan ID Number:	Claim Number:
*Date of Service:	Original Claim Amount Billed:
Dispute Type: <input type="checkbox"/> Claim Denial <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment <input type="checkbox"/> Disputing Underpayment of Claim Paid <input type="checkbox"/> Other (Please Specify): _____	
*Description of Dispute:	
Expected Outcome:	
Contact Name:	Title:
Signature:	Date:
Phone Number:	Fax Number:

Mark here if additional information is attached. Please do not staple.

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