NextLevelHealth
A healthier you. A healthier community.

Claims Dispute Request Form (CDR)

Section 1: General Information

- Please complete the entire form and provide any additional information necessary for the expected outcome. Please use the tab key to move from field to field. Use the spacebar to check the appropriate boxes.
- Dispute must be received within 90 days of original remittance advice
- Allow 60 calendar days to process this reconsideration
- For follow-up, please call NextLevel Health at 833-275-6547
- Be specific when completing the "Describe Dispute" attaching any appropriate documentation
- Please select your participation: ____ Participating Provider ____ Non-Participating Provider
- Number of attached pages _____
- Complete form and mail with supporting documentation to:

  NextLevel Health
  Attention: Claims Disputes
  P.O. Box 5050
  Farmington, MO 63640

NOTE: <u>This form is ONLY for submitting a claims dispute for reconsideration. Refer to your provider manual or billing guidelines for other claims related requests.</u>

Claim Number: (Only include 1 claim per request)		**Member ID#:**	
Member name:		**Date of Birth:**	**Date of Service:**
Provider Name:		**Billed Charges:**	**Final Payment:**
Provider ID (TIN):	**NPI:**	**Provider Phone #:**	**Provider Fax #:**

Type of Claim Reconsideration:

Please check all applicable reason(s) and attach all supporting documentation	
___ **Billing:** Claim processed under incorrect provider NPI/TAX ID:	___ **Medical Necessity:** Attach copy of Prior Authorization request or explanation. ____ **Member Eligibility**
__ **Edit Error:** Attach supporting documentation/medical records	____**Timely Filing:** Attach claim and any supporting documentation demonstrating timely filing.
Coordination of Benefits Information: ___ Alternate Insurance Information / EOP Attached ___ COB-Related Adjustment ___ Other: Please describe	**Reimbursement:** __ Under/Overpayment __ Pre-Authorization on file- Prior Auth # __ Claims Reversal Needed
Describe Dispute in Detail: (___) Additional pages included	

Contact Name: **Phone:**

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