



INSTRUCTIONS:

- This form must be returned within **6 months** from the date on the applicable Remittance Advice to initiate the claim dispute process.
- Use one form for each disputed claim.
- Provide a clear rationale for your dispute, and any additional documentation (such as medical records) that will support your request for payment.
- Please allow 30 days to elapse before checking the status of your dispute.
- Mail or fax this form to:

Health First Health Plans	Fax: (321) 434-5655
Claims Resolution Unit	
6450 US Highway 1	
Rockledge, FL 32955	
- Health First Health Plans will resolve your dispute within **60 days** of receiving this form.
- If the reconsidered decision is in your favor, you will receive a corrected payment and a new Remittance Advice. If the decision is not in your favor, you will receive a letter explaining the reason for the decision.
- **Note:** According to Florida Statutes (FS 641.3154) you may not balance bill members of Health First Health Plans during this process.

PROVIDER INFORMATION

Provider Name:	Contact Person:
Provider Billing Address:	
Phone Number:	Fax Number:

PATIENT INFORMATION

Patient Name:	Patient ID#:	Patient Date of Birth:	Plan Type (i.e. Medicare, Commercial, TPA)
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CLAIM INFORMATION

Date of Service:	Amount Billed:	Amount Paid:	Claim# and Line Item:
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DISPUTE INFORMATION

Describe the desired outcome and why you feel it is appropriate. Attach supporting documentation if necessary.

Authorized Representative Name (please print) Title

Authorized Signature Date

? Check here if additional information is attached
(Please use paper clip. Do not staple.)

Health Plan use only: