Provider Claim Dispute Form

Supporting documentation is required with all submissions for dispute to be considered.

FAX: 1-866-339-8751; ATTN: Provider Claim Disputes

IMPORTANT NOTE: Request can take up to 60 days to process and review. If you have questions or would like to check the status of your request, please contact ATRIO Provider Customer Service 877- 672-8620. **Your request must be received in writing and will only be reviewed through this process once.**

Hours: Monday - Friday, 8AM - 5PM PST.

Complete the following information below:

Provider Payment Dispute: Providers disputing the way a claim was paid.
Par Provider Reconsideration: A contracted provider may file when a claim or claim line is denied. This is not a CMS requirement, but a service provided by ATRIO to contracted providers.

Payment Issue Type*

Provider Payment Dispute

Par Provider Reconsideration

Type of Provider*

Contracted

Non-Contracted

Provider Information

Contact Name*

First Name *Last Name*

Provider/Facility Name*

Contact Mailing Address*

Contact Email Address*

Contact Phone Number*

Contact Fax Number*

Provider Claim in Dispute Information*

Claim #: _______________ **Member Name:** ____________________ **Member ID:** _____________

Date(s) of Service: ____________________ **Total Payment Amount Expected:**_________________

Please continue to page 3 to provide the dispute reason...

Reason for Payment Dispute or Reconsideration:*

Provider's Signature:* **Signature Date:*** **Signature Time:***