TexanPlus® HMO/HMO-POS/HMO-SNP
A WellCare Company

Provider Dispute Resolution Request Form

Instructions:
Please fully complete the form. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Please provide supporting documentation to support your appeal.

Mail the completed form to: Provider Dispute Resolution
TexanPlus
P.O. Box 18500
Austin, TX 78760-8500

Or fax the complete form to: 1-877-656-1728

Provider Name:	Provider Tax ID#/Medicare ID#:
Address:	

Provider Type: ☐ MD ☐ Mental Hospital ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Home Health ☐ Rehab ☐ Ambulance ☐ Other ______________ (Please specify)

Claim Information ☐ Single ☐ Multiple "LIKE" Claims (Please provide listing)
Number of claims ______________

*Patient Name:		*Date of Birth:
*Health Plan ID #:	Patient Account Number:	Original Claim ID Number (if multiple cases provide separate listing):
*Service From/To Date:	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type:
☐ Claim
☐ Appeal of Medical Necessity
☐ Requirement for Reimbursement of Overpayment
☐ Seeking Resolution of Billing Determination
☐ Other

*Description of Dispute:

*Expected Outcome:

______________________________ (____)______________
Contact Name (Please Print)

______________________________ (____)______________
Contact Name (Please Print)

☐ Check if additional information is attached.

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