TRIBUTE® HMO SNP

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: Tribute – Provider Dispute Resolution
4888 Loop Central Drive, Suite 700
Houston, Texas 77081

Or fax the complete form to: (713) 972-0247

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 Nessity
☐ Requirement for Reimbursement of Overpayment
☐ Seeking Resolution of Billing Determination
☐ Other

*Description of Dispute:

*Expected Outcome:

_____ _____ (____)_____
Contact Name (Please Print) Title Phone Number

_____ _____ (____)_____
Contact Name (Please Print) Title Phone Number

☐ Check if additional information is attached.