Postservice Appeal and Claim Dispute Form
For Contracted Providers

HealthSpring℠

Complete the top section of this form. Check the box that most closely describes your appeal or dispute reason. Include any supporting documentation, as indicated below. We can't process requests received without required information.

If your request is related to a preservice denial, use the correct form on the **HealthSpring.com/Providers** forms page.

Request for appeal or claim disputes and reconsiderations

Member first name	Middle initial	Member last name	Member identification number

Date of birth / /	Claim number	Line item number	Dates of service

Provider or contact name	National Provider Identifier	Phone	Fax

Contracted provider appeals

Reason for appeal

- ☐ Observation or inpatient medical
- ☐ Medical necessity denial
- ☐ No prior authorization
- ☐ Service provided before authorization was effective
- ☐ Member in hospice
- ☐ Service not covered by Medicare
- ☐ Duplicate claim
  If the original claim was denied for any of the above reasons for appeal, please check this box and the original denial reason listed.
- ☐ Postservice claim audit or payment recovery for any of the listed reasons.

Submit appeals to: HealthSpring Part C Appeals
PO Box 188081
Chattanooga, TN 37422

Fax: 855-699-8985

Claim disputes or reconsideration

Reason for dispute or reconsideration:

- ☐ Coordination of benefits
- ☐ Invalid or missing modifier
- ☐ NPI or tax identification number mismatch
- ☐ Invalid diagnosis or Current Procedure Terminology (CPT®) codes
- ☐ Claim was not paid in accordance with contract allowable rate
- ☐ Not within the scope of contract
- ☐ Medically unnecessary edits
- ☐ Request for additional information
- ☐ Include copy of letter or request received
  - Provide missing or incomplete information
    - Coding dispute - Timely filing
  - Remittance advice, explanation of benefits or other documentation of filing original claim
- ☐ Bundled service
- ☐ Claim timely filing denials
- ☐ Additional information required
- ☐ Itemized bill required
- ☐ Duplicate claim
  If the original claim was denied for any of the listed reasons for dispute/reconsideration, please check this box and the original denial reason listed.
- ☐ Postservice claim audit or payment recovery for any of the listed reasons

Submit disputes to: HealthSpring Services
Attn: Medicare Claims Department
Contracted Provider Payment Disputes
PO Box 20002
Nashville, TN 37202

If you have multiple reconsideration requests for the same health care professional and payment issue, indicate this in the notes below and include a list of the following: member ID number, claim number and date of service.

If the issue requires supporting documentation as noted above, it must be included for each individual claim. If no additional documentation is required for your appeal or reconsideration request, fax in only this completed cover sheet.

You may use the space below to clearly describe your reason for appeal or claim dispute or reconsideration.