ANTIDOTE

Antidote Health Plan of Arizona, Inc.
Antidote Health Plan of Ohio, Inc.

Provider Dispute Form

Instructions: Please complete Sections 1-5 of this form. Fields with an asterisk (*) are required for processing. Disputes without the required fields completed may be returned. If the claim is denied and Antidote Health Plan (Antidote) is **requesting additional information**, please **submit a corrected claim** with the additional information to Antidote at:

Antidote Health Plan of Arizona, Inc.
Payer ID: IHS05

Paper Claims:
PO Box 155
Arnold, MD 21012

or

Antidote Health Plan of Ohio, Inc.
Payer ID: 89461

Paper Claims:
PO Box 595
Arnold, MD 21012

Completed Provider Dispute Forms should be returned to:

Attn: Antidote Health Plan, Claim Disputes Department
PO Box 39638
Solon, OH 44139

or

faxed to: 1-216-504-9561

Please note the following:

- If you are appealing a denied authorization on behalf of the member, contact Member Support at 740-647-4140, 8am – 4:30pm ET Monday – Friday.
- For reconsiderations or retro-authorization requests, contact Utilization Management at 740-647-4140, 8am – 4:30pm ET Monday – Friday.
- For routine claim follow-up status, instead of submitting a dispute, please call Antidote Claims Department at 888-509-2688, 8am – 5pm ET, Monday – Friday.

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Section 1 – Provider Information

PROVIDER NPI*:	PROVIDER TAX ID*:	PROVIDER NAME*:	DATE:
PROVIDER ADDRESS*:			
PROVIDER TYPE: ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other: _____			

Section 2 – Dispute Details

DISPUTE TYPE:

☐ Claim (Underpayment/Timely Filing/EOB, etc.) ☐ Dispute of a Refund (request for reimbursement of overpayment)

☐ Appeal of Medical Necessity/Utilization Management Decision (Authorization #*_____)

☐ Contract ☐ Other: _____

Dispute Description*:

Section 3 – Claim Details

For a single claim, complete Box A. For multiple "like" disputes, complete Box B. Multiple "like" claims are for the same provider and dispute type but different Antidote members. Please attach any additional information or documentation to support the description of the dispute and select what type of attachments are included.

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Box A for single claim:

MEMBER NAME*:	MEMBER DOB*:	MEMBER ID #*:	PATIENT ACCOUNT #:
DATE OF SERVICE*:	ANTIDOTE CLAIM ID*:	ORIGINAL CLAIM AMOUNT BILLED*:	ORIGINAL CLAIM AMOUNT PAID:

ATTACHMENTS

☐ Medical Records ☐ Authorization/Referral ☐ Proof of Timely Filing ☐ Proof of Eligibility
☐ Invoice/Bill ☐ COB ☐ AOR ☐ Other: _____
☐ EOB

Box B for multiple "like" claims:

	Member Name*:		Member DOB*:	Member ID #*:	AHP Original Claim ID*:	Date of Service*:	Original Claim Amount Billed*:	Original Claim Amount Paid:
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

ATTACHMENTS

☐ Medical Records ☐ Authorization/Referral ☐ Proof of Timely Filing ☐ Proof of Eligibility
☐ Invoice/Bill ☐ COB ☐ AOR ☐ Other: _____
☐ EOB

Section 4 – Expected Outcome

Please describe the expected outcome:

Section 5 – Contact Information

CONTACT NAME*:	TITLE:	TELEPHONE NUMBER:
MAILING ADDRESS:		FAX NUMBER*:
EMAIL*:		DATE:
SIGNATURE*:		