Trillium Community Health Plan

Provider Claim Dispute Form

Provider Name: ______________________ Provider Number: ______________
(NPI or TIN)

Claim Dispute Information

Claim Number: ______________________ Date(s): ______________
(Located on your EOP directly beneath the patient name)

Member Name: ______________________ Member Number: ______________

Date Claim Denied: ______________________ Date Submitted: ______________

Service Denied: ____

- ☐ Attach a copy of the waiver signed and dated by the Trillium member if this relates to a claim for non-covered services.

Reason/Issue for Dispute

- ☐ **Claim Denied – No Authorization:**
  - ☐ No authorization was required
  - ☐ Authorization obtained # ______________________
- ☐ **Claim denied – not filed timely:**
  - ☐ Please attach proof of timely filing.
- ☐ **Paid to incorrect provider:**
- ☐ **Incorrect payment amount:**
  - ☐ Please attach an explanation.
- ☐ **Claim denied – clinical reason:**
  - ☐ Please attach documentation of review by a licensed clinician and the specific reason why that clinician disagrees with Trillium's decision.
- ☐ **Other:**
  - ☐ Please attach an explanation.

Batch Submission of Similar/Like Disputed Claims

Provider Name: ______________________ Provider Number: ______________

# of Claims attached: ______________________ Control Claim Numbers: ______________

- ☐ Please attach an explanation. *(No more than 25 at a time)*

Submit Completed Form(s) and Attachments To:

Medicaid:
Trillium Community Health Plan, Attn: Dispute
P.O. Box 5030, Farmington, MO 63640-5030

Medicare:
Trillium Medicare Advantage, Attn: Corrections, Reconsiderations or Disputes
P.O. Box 4000, Farmington, MO 63640-3822

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