Geisinger Health Plan PO
Box 853910
Richardson, TX 75085-3910
Fax number 570-214-9366

# NON PARTICIPATING PROVIDER DISPUTE RESOLUTION REQUEST

***NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.***

- Please complete the below form. Fields with an asterisk (*) are required. For the online editable form, use the tab key to move from field to field. Use the spacebar to check the appropriate boxes.
- Please complete this form if you are seeking reconsideration of a previous billing determination.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Mail the completed form to: Claims Department
  PO Box 853910
  Richardson, TX 75085-3910

| **Provider Name:** | **Tax ID #:** |
|---|---|
| **Provider Address:** | |

Provider Type: ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC

☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other

CLAIM INFORMATION

| *Patient name : | | Date of Birth: |
|---|---|---|
| *Health Plan ID Number: | Patient Account number: | Original Claim Number: |
| Service Date: | Original Amount Billed: | Original Amount Claim Paid: |
| Dispute Type ☐ Request for reimbursement of Overpayment ☐ Claim<br>☐ Additional payment request ☐ Other_____ | | |

| Description of dispute and desired outcome: |
|---|
| |

Contact Name (Please print) _____ Phone number _____

Signature_____ Date_____ Fax Number_____

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**