Arizona Complete Health – Complete Care Plan
Attention: Provider Claim Disputes
1870 W. Rio Salado Parkway, Suite 2A
Tempe, AZ 85281-2494

# PROVIDER STATE FAIR HEARING REQUEST

**INSTRUCTIONS**

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Provider Inquiry Request form instead of this form.

Mail the completed form to the following addresses. Please note the specific address for all AzCH disputes.

Arizona Complete Health – Complete Care Plan
Attention: Provider Claim Disputes
1870 W. Rio Salado Parkway, Suite 2A, Tempe, AZ 85281-2494

For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

| ***PROVIDER NAME:** | ***PROVIDER TAX ID #:** |
|---|---|
| **PROVIDER ADDRESS:** | **Contracting: Y/N ( pls. circle)** ☐☐ |

**PROVIDER TYPE:** ☐ Physician ☐ Mental Health ☐ Hospital ☐ ASC/ Outpatient Services ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other Professional (please specify type of "other")_____

***CLAIM INFORMATION:** ☐ Single ☐ Multiple "**LIKE"** Claims (complete attached spreadsheet) Number *of claims*:____

| ***Patient Name:** | | **Date of Birth:** |
|---|---|---|
| ***Social Security Number :** | ***AHCCCS ID:** | ***Original Claim ID Number:** (If multiple claims, use attached spreadsheet) |
| ***Service "From/To" Date:** | **Original Claim Amount Billed:** | **Original Claim Amount Paid:** |

**Dispute Type:** ☐ Claim ☐ Appeal of Medical Necessity/Utilization Management Decision ☐ Contract Dispute ☐ Seeking Resolution of a Billing Determination ☐ Disputing a Request For Reimbursement of Overpayment ☐ Other

***DESCRIPTION OF DISPUTE: INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND RATIONALE** (Additional paper can be attached if necessary)

***EXPECTED OUTCOME: PLEASE PROVIDE BY CLAIM, IF MULTIPLE**

| | | |
|---|---|---|
| **Contact Name (please print)** | **Title** | **( ) Telephone # (w/area code)** |
| **Signature and date** | **Email address** | **( ) Fax # (w/area code)** |

[ ] ***CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:***
**(Please do not staple information)**



**For Health Plan Use Only**
**Case #** _____
**Provider #** _____

# PROVIDER STATE FAIR HEARING REQUEST

**INSTRUCTIONS: (For use with multiple "like" claims only)**

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
  Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Provider Inquiry Request Form instead of the Provider Dispute Resolution Form.

Mail the completed form to the following addresses.

Arizona Complete Health – Complete Care Plan
Attention: Provider Claim Disputes
1870 W. Rio Salado Parkway, Suite 2A, Tempe, AZ 85281-2494

For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

| Number | *Patient Name | | Date of Birth | *Member ID No./ AHCCCS Number | *Original Claim ID Number | *Service From/To Date | Original Claim Amount Billed | Original Claim Amount Paid | *Expected Outcome |
|---|---|---|---|---|---|---|---|---|---|
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[ ] ***CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:***
**(Please do not staple information)**



**For Health Plan Use Only**

**Case #** _____

**Provider #** _____