ULTIMATE HEALTH PLANS
Good health is where you live.

Participating Provider Claim Complaint Form

FAX TO: 352-515-5979 EMAIL TO: ultclaims@ulthp.com

MAIL TO: 1244 Mariner Boulevard, Spring Hill, FL 34609

Today's Date:

Requester Information

Provider Name:		Provider # or TIN:	
Practice Name:		Contact Name:	
Telephone Number:		Fax Number:	
Address:	City:	State:	Zip:
Authorized Signature:			

Reason for Request

☐ Claims Issue (check below} ☐ Contract Dispute ☐ Change in Network Status ☐ Other (explain}: _____

- ☐ Clinical Edit/Bundling
- ☐ Timely Filing Denial
- ☐ Assistant Surgeon/Surgical Assistant Not Allowable
- ☐ No Authorization on File

Please Provide Any Additional Information about Request Below:

Claim Information

Member (Patient} Name:		Member ID #:	Date of Service:
Claim #:	Billed Amount: $	Disputed Amount: $	Processed Date:

Supporting Documentation - Please indicate the type of documentation attached:

- ☐ Proof of timely filing (fax or mail receipt, etc.}
- ☐ Office / progress notes
- ☐ Medical records
- ☐ Procedure / operative report
- ☐ Original claim action request
- ☐ Applicable Contract Excerpt
- ☐ Other _____

Multiple Claims Review Request Form

#	Patient Last Name	Patient First Name	Subscriber ID	Claim Number	Date of Service		Billed Amount	Payment Amount	Expected Outcome
					From	To			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									