ULTIMATE HEALTH PLANS
Good health is where you live.

Participating Provider Dispute Resolution Request

FAX TO: (800) 313-2798 EMAIL TO: grievanceandappeals@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	Date of Birth	Plan ID (001 / 002)	Original Claim #	Date of Svc.		Original Billed Amt.	Original Paid Amt.	Expected Outcome
						From	To			
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Check here if additional information is attached [ ]