



## Provider Claims Dispute Form

Provider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Member Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_

RID#: \_\_\_\_\_ MDwise Participating Provider:    Yes    No

Service(s) Disputed: \_\_\_\_\_

Describe disputed claim. Description should include, but not be limited to the following items: reason given for denial and position statement that explains why this claim should be paid.

**Please attach a copy of the Explanation of Benefits and/or denial letter and any documentation that you believe may be relevant to support this request.**

Form Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Please send completed form to:  
MDwise  
PO Box 441423  
Indianapolis, IN 46244-1423  
Attn: MDwise Grievance Coordinator

