MDwise Marketplace Provider Claims Dispute Form

Facility/Provider Name: _____ Date: _____

Telephone Number: _____ Fax Number: _____

Patient Name: _____ Date of Service: _____

Patient ID: _____

MDwise Program: ◯ Hoosier Healthwise ◯ HIP ◯ Hoosier Care Connect ◯ MDwise Marketplace

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 red lined claim, Explanation of Benefits and/or denial letter and any documentation that you believe may be relevant to support this request.

Form Completed By *(please print)*:

_____ Date: _____

Please send completed form to:
MDwise Marketplace
P.O. Box 441099
Indianapolis, IN 46244-1099
Attn: MDwise Grievance Coordinator

Please provide correspondence address:

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