Claims Dispute Form

Please submit disputes electronically to **cdticket@mdwise.org**.
Only **ONE** claim can be submitted **PER** dispute form **PER** email.

Facility/Provider Name: _____ Date: _____

Telephone Number: _____ Email: _____

Member Name: _____ Date of birth: _____

Date of Service: _____ Member ID #: _____

Billed Amount: _____ Claim #: _____

Dipute: ◯ 1st level ◯ 2nd level
(please select one)

MDwise Program: ◯ Hoosier Healthwise ◯ HIP ◯ MDwise Marketplace ◯ Hoosier Care Connect
(please select one)

Claim dispute denial reason: _____

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, as available, explanation of payment, denial letter and any documentation that you believe may be relevant for your claim dispute.

Form Completed By *(please print)*:

_____ Date: _____

If you are unable to email disputes please mail them to the following address:
MDwise
P.O. Box 441423
Indianapolis, IN 46244-1423
Attn: MDwise Dispute Team

Please provide correspondence address:

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