



# Claims Dispute Form

Please submit disputes electronically to [cdticket@mdwise.org](mailto:cdticket@mdwise.org). Only **ONE** claim can be submitted **PER** dispute form **PER** email. Please use a Claim Adjustment Form for corrected claims, medical records, invoices, consent forms or recoupment requests. These do not constitute a dispute.

Facility/Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Member Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Billed Amount: \_\_\_\_\_ Claim #: \_\_\_\_\_

MDwise Program:      Hoosier Healthwise      HIP  
(please select one)

Dispute Level:      1st Level      2nd Level  
(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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