Claims Appeal & Dispute Form

This form is to be used to request a redetermination if SevaRx overpaid, underpaid, or denied your claim. Please fill out every section of this form – if not, your request may be placed on hold until we receive the correct information.

Provider Information ☐ INN ☐ OON
Provider/Group Name:
Tax ID or NPI:

Patient Information
Patient Name:
Member ID: CP

Attachments
Remittance Advice ☐ Medical Records ☐
Supporting Documentation for Dispute ☐
Waiver of Liability (REQUIRED for OON) ☐

Contact Information
Name:
Address:
Phone #: ( )
Fax #: ( )

Claim Information
Patient Account Number:
Claim Number:
Date of Determination*
Date(s) of Service:

Reason for Request (Choose the Reason Below)
Overpayment ☐ Underpayment** ☐ Denial Code(s) ☐ _____. Amount Paid: $ _____ Expected Amount: $_____.
Whole Claim: ☐ CPT Code(s): _____
Other: (Please Provide a Description and/or a Good Cause Reason)

Return Information	
INN providers should submit requests to:	OON providers should submit requests to:
Mail: 10996 Four Seasons Place, Suite 101,Crown Point, IN 46307	Mail: 10996 Four Seasons Place, Suite 101,Crown Point, IN 46307
Email:	Email:
Phone:833-273-2253	Phone: 833-273-2253

*Please provide good cause above if dispute is filed after 60 days from the date of determination.

**Inquiries are considered underpayments only if the whole claim or the code being disputed was initially paid.