INSTRUCTIONS: The Contractor shall utilize the instructions listed on this page to assist with completing Attachment A.

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| **PROVIDER/COMPLAINANT** |
| PROVIDER/COMPLAINANT NAME: | LEGAL NAME OF THE PERSON/ENTITY WHO PROVIDED THE SERVICE AS REGISTERED WITH AHCCCS | TYPE (MD, DO, PA, ETC.): | MEDICAL DR, HOSPITAL, INPATIENT FACILITY ETC. |
| AHCCCS PROVIDER ID: | SIX DIGIT NUMBER THAT AHCCCS ASSIGNED TO THE PROVIDER WHEN APPROVED FOR ENROLLMENT WITH AHCCCS TO PROVIDE SERVICES. | PHONE NUMBER: | ACTIVE PROVIDER TELEPHONE NUMBER |

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| ADDRESS: | PROVIDER ADDRESS SHOULD MATCH WHAT THE PROVIDER HAS USED TO REGISTER WITH AHCCCS (PROVIDER ID) AND CORRESPOND WITH THE PERSON/ENTITY PROVIDING SERVICE.  |

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|  **COMPLAINANT HEARING REPRESENTATIVE** |
| HEARING REPRESENTATIVE: | WHO WILL BE REPRESENTING THE PROVIDER/COMPLAINANT AT THE HEARING. THIS IS TYPICALLY THE CONTACTED PERSON/ENTITY WHO REQUESTED THE HEARING. COULD BE A BILLING REPRESENTATIVE OR AN ATTORNEY.  |
| PHONE NUMBER: | ACTIVE TELEPHONE NUMBER | ADDRESS: | ADDRESS TO WHICH LEGAL DOCUMENTS INCLUDING THE NOTICE OF HEARING WILL BE SENT |

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| **CLAIM DISPUTE** |
| DATE(S) OF SERVICE: | DATE SERVICES WERE PROVIDED. CAN BE A SINGLE DATE OR A RANGE (IF RANGE, PLEASE LIST IN CHRONOLOGICAL ORDER WITH EARLIEST DATE FIRST: EXAMPLE: 01/01/2023 TO 12/01/2023. DO NOT LIST AS 12/01/2023 TO 01/01/2023.) | BILLED AMOUNT: | $ TOTAL DOLLAR AMOUNT BILLED VIA THIS CLAIM DISPUTE |
| CLAIM DISPUTE ISSUE CATEGORY: | WHY WAS THE CLAIM DISPUTED? EXAMPLE: MEDICAL NECESSITY |

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| ISSUE TO BE HEARD AT HEARING: | WHAT IS THE ISSUE THE PROVIDER IS REQUESTING THE COURT HEAR. EXAMPLE: WERE THE SERVICES PROVIDED MEDICALLY NECESSARY? |
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| LEGAL CITATIONS:  | EXAMPLE: PURSUANT TO AAC R9-22-202(B)(1). “ONLY MEDICALLY NECESSARY, COST EFFECTIVE, AND FEDERALLY REIMBURSABLE AND STATE-REIMBURSABLE SERVICES ARE COVERED SERVICES.” |
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| CONTRACTOR DISPUTE NUMBER: | THE HEALTH PLANS ASSIGNED DISPUTE NUMBER.  |
| **MEMBER INFORMATION** |
| MEMBER NAME: | MEMBER THAT SERVICES WERE PROVIDED TO | MEMBER’S AHCCCS ID NUMBER: | MEMBER’S AHCCCS ID NUMBER |
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| EXPEDITE: [ ] Yes [ ]  No |

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*\*End of instructions.*

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| **PROVIDER/COMPLAINANT** |
| PROVIDER/COMPLAINANT NAME: |  | TYPE (MD, DO, PA, ETC.): |  |
| AHCCCS PROVIDER ID: |  | PHONE NUMBER: |  |

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| ADDRESS: |  |

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| **COMPLAINANT HEARING REPRESENTATIVE** |
| HEARING REPRESENTATIVE: |  |
| PHONE NUMBER: |  | ADDRESS: |  |

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| **CLAIM DISPUTE** |
| DATE(S) OF SERVICE: |  | BILLED AMOUNT: | $ |
| CLAIM DISPUTE ISSUE CATEGORY: |  |

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| ISSUE TO BE HEARD AT HEARING: |  |
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| LEGAL CITATIONS:  |  |
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| CONTRACTOR DISPUTE NUMBER: |  |
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| **MEMBER INFORMATION** |
| MEMBER NAME: |  | MEMBER’S AHCCCS ID NUMBER: |  |
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| EXPEDITE: [ ] Yes [ ]  No |

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