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 | |
| |  | | --- | | EXPEDITE: Yes  No | | | | |  | | | |

*\*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: |  | |
| |  | | --- | | EXPEDITE: Yes  No | | | | |  | | | |