Humana | Healthy Horizons™ in Kentucky

Claim Dispute Form

CLAIM TYPE: ___ UB-04 ___ HCFA-1500 ___ ADA

PATIENT INFORMATION

DATE OF SERVICE: _____ CLAIM #: _____
NAME: _____
HUMANA HEALTHY HORIZONS ID NUMBER:_____

PROVIDER INFORMATION

NPI: _____ TAX ID #: _____

ADDRESS:
_____
NAME AS IT APPEARS ON W–9:
_____

REQUESTOR INFORMATION

NAME: _____
ADDRESS:
_____
EMAIL: _____ PHONE: _____

Select the most appropriate claim dispute reason*:

__ Incorrect payment
__ Clinical edit
__ Timely filing
__ Recoupment notice
__ Procedure dispute
__ Consent form
__ Duplicate claim
__ Eligibility
__ Provider ID dispute
__ Coordination of benefits

****Please note: Claim disputes must be connected to payment errors specifically related to provider contract issues. All other issues must be submitted via the Humana Healthy Horizons in Kentucky appeals process.***

Please give a brief but detailed description of your claim dispute:
_____
_____
_____

What is your expected outcome of the claim dispute?
_____
_____
_____

Humana | Healthy Horizons™ in Kentucky

Have you submitted a previous appeal or claim dispute in relation to the claim you dispute via this submission? _____

If so, please provide the Humana Healthy Horizons appeal or claim dispute reference number:_____

When submitting this form, attach pertinent documentation that supports the claim dispute. Incomplete submissions will be rejected. Pertinent attachments must include, at minimum, the explanation of payment (EOP) for the disputed claim and the provider contract provision that you believe Humana Healthy Horizons misapplied in the processing of the disputed claim. Other attachments are not mandatory, but will be accepted.

NUMBER OF ATTACHED PAGES: _____

SUBMIT APPEALS AND CLAIM DISPUTES TO:

Provider portal: www.humana.com/KentuckyMedicaid

- **Mail:** Humana Healthy Horizons in Kentucky
  Attn: Provider Correspondence
  P.O. Box 14601
  Lexington, KY 40512-4601

- **Fax:** 1-800-949-2961

Providers/facilities have 24 months from the original adjudication date to file a claim dispute. Provider disputes will be resolved by Humana Healthy Horizons in Kentucky within 30 calendar days of receipt.

Please do NOT use this form to submit corrected claims.

***Corrected claims** should be sent to:*

Humana Healthy Horizons in Kentucky
Attn: Claims Department
P.O. Box 14601
Lexington, KY 40512-4601

If you have questions, please call 1-800-444-9137.