Humana®

Provider Payment Integrity (PPI)
Medical Record Review Dispute Request Form

Please complete and attach this form to your formal letter of dispute to ensure your documentation is routed appropriately. Be sure to include the original Medical Record Review Initial Findings Letter and any other documentation that supports your dispute.

Healthcare provider's name: _____

State of practice: _____

Healthcare provider's address: _____

1. Please indicate the type of dispute: ☐ Review findings ☐ Claim payment If this is a payment dispute, please note the amount being disputed: $_____ Has this amount been previously disputed? ☐ Yes ☐ No
2. What Humana claim number do you wish to dispute? _____ Note: If you wish to dispute multiple claims, please mail or fax them separately.
3. Is the disputed claim a corrected claim? ☐ Yes ☐ No If yes, what is the original billed claim number? _____
4. What level of dispute is this (if applicable)? ☐ 1 ☐ 2
5. What type of policy does this dispute involve? ☐ Medicaid ☐ Medicare ☐ Commercial
6. Are you a participating (contracted) or nonparticipating (noncontracted) healthcare professional? ☐ Participating ☐ Nonparticipating
7. Patient's name:
8. Patient's account number:
9. Medicaid ID number:
10. Patient's date of birth:
11. Date(s) of service on claim: