



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. Fax materials to 888-815-8912 or mail to:

Humana Provider Payment Integrity Disputes
P.O. Box 14279
Lexington, KY 40512-4279

Healthcare provider's name: _____

State of practice: _____

Healthcare provider's address: _____

1. Please indicate the type of dispute: <input type="checkbox"/> Review findings <input type="checkbox"/> Claim payment If this is a payment dispute, please note the amount being disputed: \$ _____ Has this amount been previously disputed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the original billed claim number? _____
4. What level of dispute is this (if applicable)? <input type="checkbox"/> 1 <input type="checkbox"/> 2
5. What type of policy does this dispute involve? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial
6. Are you a participating (contracted) or nonparticipating (noncontracted) healthcare professional? <input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating
7. Patient's name:
8. Patient's account number:
9. Humana ID number:
10. Patient's date of birth:
11. Date(s) of service on claim: