Provider Inquiry and Appeal Form

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

Instructions

Before submitting form, have done the following:

- Reached out to your Provider Rep or customer service
- Checked our policies on our website
- Reviewed your contract
- Reviewed EOCCO policies online

Please complete the form below. Fields with an asterisk (*) are required. Be specific when completing the DESCRIPTION OF DISPUTE. Provide additional information to support the description of the dispute. Supporting documentation to consider including: Corrected Claim, Chart Notes, Contract Language, etc. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.

*Provider NPI:	Provider tax ID:	
* Provider name:		
☐ Reconsideration (Inquiry) ☐ First Level Appeal ☐ Second Level Appeal		
Claim information: ☐ Single ☐ Multiple "Like" Claims (complete attached spreadsheet); Number of claims _____		
* Patient name:	* Date of birth:	* Original claim number:
* Subscriber ID:	* Group number:	Procedure code:
Service "from/to" date:	Original claim amount billed:	Original claim amount paid:
Dispute type: ☐ Claim denial or reduction ☐ Appeal of Medical Necessity/Utilization ☐ Management Decision ☐ Network dispute ☐ Contract Dispute (please provide supporting contract language) ☐ Other: _____		
* Description of dispute:		
Contact name:	Phone number:	
Contact title:	Fax number:	
Signature: X	Date:	

☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

Mail or fax the completed form and supporting documentation to:

EOCCO
Provider Appeal Unit
P.O. Box 40384, Portland, OR 97240
Fax Number 855-260-4527

Incomplete or inaccurate forms will be returned to the provider until complete and accurate information is received.

Provider dispute resolution request

For use with multiple "LIKE" claims (claims disputed for the same reason)

Claim #	* Patient name: Last	* Patient name: First	Date of birth:	* Subscriber ID:	Original claim ID number:	* Service "from/to" date:	Original claim amount billed:	Original claim amount paid:
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2								
3								
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