Provider Claim Dispute Form

Supporting documentation is required with all submissions for dispute to be considered.

FAX: 1-866-560-2090; ATTN: Provider Claim Disputes

IMPORTANT NOTE: Your request must be received in writing and will only be reviewed through this dispute process once. Requests can take up to 60 days to process and review. If you have not received a response after 60 days from submission, you can email providercustomerservice@atriohp.com to check the status of the dispute.

Hours: Monday - Friday, 8AM - 5PM PST.

Complete the following information below:

Provider Payment Dispute: Providers disputing the way a claim was paid.
Par Provider Reconsideration: A contracted provider may file when a claim or claim line is denied. This is not a CMS requirement, but a service provided by ATRIO to contracted providers.

Payment Issue Type*

- ○ Provider Payment Dispute
- ○ Par Provider Reconsideration

Type of Provider*

- ○ Contracted
- ○ Non-Contracted

Provider Information

Contact Name*

First Name *Last Name*

Provider/Facility Name*

Contact Mailing Address*

Contact Email Address*

Contact Phone Number*

Contact Fax Number*

Provider Claim in Dispute Information*

Claim #: _____ Member Name: _____ Member ID: _____

Date(s) of Service: _____ Total Payment Amount Expected:_____

Please continue to page 3 to provide the dispute reason...

Reason for Payment Dispute or Reconsideration:*

Provider's Signature:* **Signature Date:*** **Signature Time:***