Provider Claim Dispute Form

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

A **dispute** is defined as a request from a health care provider to change a decision made by First Choice Next related to claim payment or denial for services already provided. A provider dispute is not a preservice appeal of a denied or reduced authorization for services or an administrative complaint.

Submitter/Contact information		
Name (Last, First)	Submission date	Phone

Provider information		
Provider name (Last, First)	NPI #	Tax ID #
Phone	☐ I am a participating provider. ☐ I am **not** a participating provider.	

Enrollee information		
Enrollee name (Last, First)	Date of birth	Enrollee ID #

Claim information		
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)

Attach additional sheets if necessary.

Payment Dispute Section To ensure timely and accurate processing of your request, please check the applicable reason below for your dispute.	
☐ Inaccurate payment	☐ Denied for no primary payer EOB (EOB attached)
☐ Post-service authorization denial	☐ Denied for no authorization (service does not require authorization)
☐ Denied as a duplicate	☐ Denied for no authorization (auth. # on file)
☐ Clinical edit limitation or denial	☐ Untimely filing (proof of timely filing attached)
☐ Other:	
Additional information:	

Please mail this completed form and any supporting documentation to:

First Choice Next
Provider Claims Disputes
P.O. Box 7186
London, KY 40742-7186