Provider Dispute Resolution Form

Decent

Disputes must be filed within 365 days of the last date of decision or communication by Decent

If you have not previously addressed this issue with Decent please call **1-866-Heart-Us** to speak with a representative. This matter should undergo a preliminary review before filing a dispute.t

Filling out this completed form will constitute a provider initiating a formal Dispute with Decent and will trigger Decent's Dispute Resolution Process

- Please complete this form (all fields with * are required), and mail to:

  BY MAIL:
  Decent
  PO Box
  Seattle, WA 98194

- You can also email this form to **Support@decent.com**
- Please call Decent at **1-866-Heart-Us** if you want to check on the status of your Dispute

PROVIDER INFORMATION

* Provider Name: * Provider NPI:

* Provider Tax ID Number:

* Provider Address:

* Phone: Fax: Email:

***provider type (please check box):**

- ☐ Physician
- ☐ Ancillary
- ☐ Hospital
- ☐ Ambulatory Surgical Center
- ☐ Skilled/General Nursing Facility
- ☐ Durable Medical Equipment
- ☐ Rehabilitation Center
- ☐ Home Health
- ☐ Ambulance
- ☐ Assisted Living Facility
- ☐ Other (please specify):

DISPUTE INFORMATION

***provider type (please check box):**

- ☐ Contracted Rate
- ☐ Timely Filing
- ☐ Out-of-network review
- ☐ Benefits decision
- ☐ Claims messages
- ☐ Health plan refund request
- ☐ Prompt Payment
- ☐ Home Health
- ☐ Request for additional information
- ☐ Other (please specify):

DISPUTED CLAIM INFORMATION

If there are multiple claims being disputed please use template spreadsheet

* Provider Name:

* Patient's ID number:

* Claim ID:

* Date(s) of Service:

DISPUTE DESCRIPTION

☐ Check here if supporting documentation is enclosed

Please be specific and include how you would like this to be resolved: