PASSPORT ADVANTAGE (HMO SNP)

PARTICIPATING PROVIDER DISPUTE FORM

Note: (Dispute must be filed within 2 years of the initial claim processed date. This dispute form is for participating providers and facilities only)

SECTION I: MEMBER INFORMATION

MEMBER NAME: _____

MEMBER DOB: _____

PASSPORT ADVANTAGE MEMBER ID NUMBER: _____

SECTION II: REQUESTING PHYSICIAN OR FACILITY INFORMATION (Please Print)

NAME OF REQUESTING PHYSICIAN OR FACILITY: _____

REQUESTING PHYSICIAN OR FACILITY NPI: _____

FAX NUMBER: _____

PHONE NUMBER: _____

OFFICE CONTACT: _____

MAILING ADDRESS (Street or P.O. Box, City, State & Zip Code):

_____

SECTION III: APPEAL INFORMATION

HAS THE CLAIM BEEN FILED FOR THE SERVICE RENDERED? ☐ YES ☐ NO

(If no, the claim must be submitted before appeals can be considered for the payment of an item or service)

DATE(S) OF SERVICE: _____

DATE(S) OF DENIAL: _____

CLAIM NUMBER: _____

(Continued on back)

PASSPORT ADVANTAGE (HMO SNP)

IF YOU RECEIVED YOUR INITIAL CLAIM DETERMINATION NOTICE MORE THAN 2 YEARS AGO, INCLUDE YOUR REASON FOR THE LATE FILING:
(Attach additional pages if necessary.)

I DO NOT AGREE WITH THE DETERMINATION DECISION ON MY CLAIM BECAUSE:
(Attach additional pages if necessary.)

Completed forms accompanied by any supporting documentation should be sent to:

Passport Advantage (HMO SNP)
Attn: Grievance and Appeals
PO BOX 11245
Portland, ME 04104

Or by Fax: 1-888-727-6231

This form is intended for use only when requesting a review for post service appeal requests for claims processed by Passport Advantage (HMO SNP).