Health First Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myHFHP.org

Provider Claim Dispute Request – Second Level

INSTRUCTIONS:

- This form must be returned within 6 months (12 months for Medicare) from the date on the applicable Remittance Advice to initiate the claim dispute process.
- Use one form for each disputed claim.
- Provide a clear rationale for your dispute and any additional documentation (such as medical records) that will support your request for payment.
- Please allow 30 days to elapse before checking the status of your dispute.
- Mail this form to the address below or complete it online in our provider portal:

  Health First Health Plans
  Claims Resolution Unit
  6450 US Highway 1
  Rockledge, FL 32955

  myHFHP.org/login

- Health First Health Plans will resolve your dispute within 60 days of receiving this form.
- If the reconsidered decision is in your favor, you will receive a corrected payment and a new Remittance Advice. If the decision is not in your favor, you will receive a letter explaining the reason for the decision.

Note: According to Florida Statute FS 641.3154, you may not balance bill members of Health First Health Plans during this process.

In order for a dispute or reopening to be valid and eligible for reconsideration, the documentation should contain the following elements:

- Copy of initial uphold denial letter and/or service reference number
- Copy of EOB
- Copy of the disputed claim
- Narrative clearly identifying purpose of second level dispute
- New or additional supporting documentation to establish medical necessity

PROVIDER INFORMATION:

Provider Name:	Phone Number:	Billing Address:

PATIENT INFORMATION:

Patient Name:	Member ID#:	Date of Birth:

CLAIM INFORMATION:

Date of Service:	Amount Billed:	Amount Paid:	Claim# and Procedure Code:

DISPUTE INFORMATION:

Denial Reason:

___ Additional information needed
___ Authorization not obtained
___ Benefit maximum exceeded
___ Bundling/Unbundling
___ Coding
___ Coordination of benefits
___ Duplicate claim
___ Member eligibility
___ Not contracted for service
___ Pre-X exclusion
___ Timely filing

Payment Issue:

___ Contractual amount
___ Under/Overpayment
___ Member cost-share

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Describe your desired outcome and why you feel it is appropriate. **Attach supporting documentation.**

___ Check here if additional information is attached.

Authorized Representative Name (please print) **Title** **Date**

Health plan use only:

Health First Commercial Plans, Inc. and Health First Insurance, Inc. are both doing business under the name of Health First Health Plans. Health First Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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