# Provider Payment Dispute Form

Email, fax or mail this form, a listing of claims (if applicable), and supporting documentation to:
Evry Health Insurance Co.
PO Box 571208
Dallas, TX 75357
Email: support @evryhealth.com
Fax: 972-807-0596
Contact us: 1-855-579-3879

A dispute is defined as a request from a health care provider to change a decision made by Evry Health Insurance Co related to a claim payment. Submission for multiple claims will not be accepted. Single claim per member per dispute form. If the original claim submitted requires a correction, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

Unless otherwise stipulated, for both participating and non-participating providers, the Provider Dispute form must be submitted within 180 days from the date on the original EOP.

| Requestor Information | | |
|---|---|---|
| Name (Last, First): | Phone Number: | Fax Number: |
| Email: | Date: | Signature: |

| Provider Information (correspondence): | | |
|---|---|---|
| Name (Last, First): | | NPI: |
| Address: | | Tax ID: |
| City, State: | Zip Code: | Correspondence Preference? ☐ Mail ☐ Fax ☐ Email |

| Member Information: | |
|---|---|
| Name (Last, First): | Member Date of Birth: |
| Member ID: | |

| Claim Information: | |
|---|---|
| Evry Claim Number: | Billed Amount: $ |
| Date(s) of services: | |

To ensure timely and accurate processing, please complete the section below by checking the applicable reason for your request and attach any appropriate supporting documentation. Documentation should include a copy of the original claim (if available), remittance advice, and a narrative explaining why you are disputing the claim(s).

**Reason for dispute:**

☐ Inaccurate payment
☐ Denied for no primary payer EOB (EOB attached)
☐ Denied for no authorization (service does not require authorization)
☐ Denied as a duplicate
☐ Denied for no authorization (authorization number on file: _____)
☐ Clinical edit limitation or denial
☐ Untimely filing (proof of timely filing attached)
☐ Other:
☐ Additional information included for review. Please attach more documents if additional information is needed.