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: 469-270-3365
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.