Claim dispute form | Out-of-network/Out-of-state providers

This form is for out-of-network and out-of-state provider use. Providers participating with Priority Health must submit claim disputes in prism, our online provider portal. Out-of-network and out-of-state providers may also use prism for a faster response. (Note: All Level 2 medical necessity appeals must be submitted in prism.)

Using this form	Medical necessity (authorization) appeals	Level 1 & Level 2 claim disputes
When to use this form	When appealing an authorization / medical necessity decision	When disputing a medical or behavioral health claim decision
Deadline	Within 65 days of the authorization denial notice	Level 2: Within 180 days of the first remittance advice
Additional documentation	• New clinical documentation • Priority Health denial letter	Your dispute must include the codes requested for review and the policy that supports the payment of the claim. If the relevant policy isn't included, the dispute will be denied.
How to submit	• Behavioral Health: 616.975.0249 (fax) • All others: 616.464.7500 (fax)	Priority Health Appeals Analyst 1231 East Beltline NE Grand Rapids, MI 49525

Submitter contact information

Provider/facility name	Tax ID	Contact name
Phone	**Fax**	**Email**
Address		

Member information

Member last name	Member first name
Member ID number	**Member date of birth**

Claim information (if a claim is on file)

Claim number	Date(s) of service(s)	Total charge(s)
Inquiry number	**Disputed codes**	

Authorization information (for authorization appeals only)

Authorization number	Disputed dates of service

Explanation of claim dispute

Include the denial reason. An attached denial letter and new clinical documentation are required for authorization and related readmission disputes. If appropriate documentation isn't provided, the appeal won't be reviewed.