**[ENTITY NAME & LOGO]**

# CMS CLAIMS DISPUTE RESOLUTION
## Adjustment/Payment Made

Date:

Provider:

Member Name:
Date of Service:
Total Billed Amount:
[Claim, tracking, document] #:
PDR Date Received:
*Health Plan ID# (optional)*
*Patient Account# (optional)*

Dear Provider:

[ENTITY NAME] received a claim dispute regarding the claim referenced above. Upon careful review of this dispute, we have determined that the initial claim decision is being overturned and payment will be made.

Payment in the amount of $_____ is made for the following service(s):

**Either list line items or a description of service must be given for reason for payment.**

If you require further information regarding the resolution of this dispute, please contact the [INSERT Entity unit and contact information].

You have the right to request an additional decision from Health Net. Please forward all information regarding this claim to:

Medicare Provider Disputes
PO Box 9030
Farmington, MO 63640-9030

Health Net must receive the written request within 180 days from the date of the notification.

Sincerely,

[ENTITY NAME]
[Responsible unit]