[ENTITY NAME & LOGO]

CMS CLAIMS DISPUTE RESOLUTION
Original Claim Determination Upheld

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 upheld** for the following reason(s):

- ❑ Medicare rate paid at Area XX YEAR; and no additional amount is due.
- ❑ Additional information requested on Month date, year was never received.
- ❑ Other

This dispute process is now closed, but if you require additional information regarding the resolution of this dispute, please contact the [INSERT Entity unit and contact information]. Please use the [Claim, tracking, document] number to reference the claim.

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]

CMS Uphold Resolution Letter
PRV2014_0071d 01/27/14