vsp vision care

Provider Claim Dispute Request

Submitting this form constitutes an agreement not to bill the patient during the claim appeal resolution process.

Please Print

Doctor name _____ Date _____

Doctor ID _____ Tax ID _____

Address _____ Phone _____

City, state, zip _____

Claim information

Number of claims appeals ☐ Single ☐ Multiple (indicate number of claims) _____

Patient name _____ Date of birth _____

Member ID or last four digits of SSN _____

Claim number _____ Date of service _____

Original claim amount billed $_____ Original claim amount paid $_____

Summary of services provided _____

_____

_____

Indicate reason for appeal and a detailed description of circumstances. Please attach any supporting documentation.

_____

_____

_____

_____

_____

_____

_____

Contact name _____ Title _____

Signature _____ Date _____

Phone _____