



PROVIDER DISPUTE RESOLUTION MULTIPLE REQUESTS

(For use with multiple “like” disputes – attach this form to the main Provider Dispute Resolution Request form)

#	*Patient Name (Last / First)	Date of Birth	*Health Plan ID Number	Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
1								
2								
3								
4								
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9								
10								
11								
12								
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14								
15								