absolute total care™
Healthy Connections

1441 Main Street
Suite 900
Columbia, SC 29201

PROVIDER DISPUTE FORM

Provider/Group Name	Provider Tax ID#	Provider NPI#	Provider County	Name of Person Completing Form	Phone number	Email address

Participation Status ◯ In-Network ◯ Out of Network
Dispute Type: ◯ Credentialing ◯ Prior Authorizations ◯ Policies & Procedures ◯ Claims
Product: ◯ Medicaid

Is dispute within 30 days of receiving an adverse action? ◯ Yes ◯ No
If yes, please proceed and complete the remainder of this form.
If No, STOP. All disputes must be filed within 30 days of receiving the adverse action.

Claim Related Dispute additional information:

How many claims are being disputed? (If applicable) ◯ 1-25 ◯ 25-50 ◯ 50-75 ◯ >100

What is your expected payment for the disputed claims? (If applicable) ◯ <$500 ◯ $500-$1000 ◯ $1000-$5000 ◯ $5000-$10,000 ◯ >$10,000

Claim Example/s, please include EX Codes (minimum of 10): if >10 please submit on separate form

Claim #	EX code	Claim #	EX code

Brief Description of Dispute:

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FOR INTERNAL USE ONLY:
Dispute submitted via: ◯ **Email:** atcnetworkrelations@centene.com ◯ **Fax:** 1-866-912-3605
◯ **ATC website** ◯ **Face to face**
◯ **Mail:** Absolute Total Care, 1441 Main Street, Suite 900, Columbia, SC 29201