Participating Provider Dispute Form

Date: _____

Member Information	
Member Last Name:	
Member First Name:	
Date of Birth:	
Member Identification Number:	

Provider/Facility Information	
Contact Name:	
Phone Number (with area code):	
Fax Number (with area code):	
Email Address:	
Provider First and Last Name: (as listed on Evidence of Payment "EOP")	
Facility/Group Affiliation: (as listed on Evidence of Payment "EOP")	
Street Address:	
City, State, Zip Code:	
NPI Number:	
Tax ID Number:	

Reason for Request	
Date of Service:	
Claim #:	
CPT Code(s):	
Total Charges:	
Expected Amount:	

☐	Denied - "Exceeds Timely Filing"
☐	Denied - Requesting additional information
☐	Denied - "Coordination of Benefits"
☐	Resubmission of corrected claim – **Submit Electronically**
☐	Previously adjudicated but applied incorrect rate, resulting in over/underpayment
☐	Denied for "no authorization"
☐	Other (provide details below)

Comments – Reason for Dispute

Please include the following: **(1)** a copy of the initial claim **(2)** a copy of the EOP **(3)** all other documents supporting the request for dispute.

Submission Options: **(1) Email:** providerclaimdispute@myzinghealth.com **(2) Fax: 844-917-4458** **(3)** Mail to:
ATTN: Provider Disputes
Zing Health, Inc.
225 W Washington St Suite 450
Chicago, IL 60606