Clover Health

Claims Appeal & Dispute Form

This form is to be used to request a redetermination if Clover Health overpaid, underpaid, or denied your claim. Please fill out every section of this form – if not, your request may be placed on hold until we recieve the correct information.

Provider Information ☐ INN ☐ OON

Provider/Group Name:

Tax ID or NPI:

Patient Information

Patient Name:

Member ID: CP _____

Attachments

Remittance Advice ☐ Medical Records ☐

Supporting Documentation for Dispute ☐

Waiver of Liability (REQUIRED for OON) ☐

Contact Information

Name:

Address:

Phone #: ( )

Fax #: ( )

Claim Information

Patient Account Number:

Claim Number:

Date of Determination* _____ /_____ /_____

Date(s) of Service:
_____ /_____ /_____ _____ /_____ /_____

Reason for Request (Choose the Reason Below)

Overpayment ☐ Underpayment** ☐ Denial Code(s) ☐ _____

Amount Paid: $ _____ Expected Amount: $ _____

Whole Claim: ☐ CPT Code(s): ☐ _____

Other: (Please Provide a Description and/or a Good Cause Reason)

Return Information

INN providers should submit requests to:
Mail: P.O. Box 21164, Eagan, MN 55121
Email: submitclaims@cloverhealth.com
Fax: 1-888-240-7243

OON providers should submit requests to:
Mail: P.O. Box 21672, Eagan, MN 55121
Email: submitappeals@cloverhealth.com
Fax: 1-732-412-9706

*Please provide good cause above if dispute is filed after 60 days from the date of determination
**Inquiries are considered underpayments only if the whole claim or the code being disputed was initially paid.