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 ☐ HMO ☐ PPO

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

Claim Number:

Date of Determination* _____ /_____ /_____

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

_____ /_____ /_____

Reason for Request (Please Select One)

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

Amount Paid: $ _____ Expected Amount: $ _____

Whole Claim: ☐ CPT Code(s): ☐ _____

Other (Please provide a description)

Return Information

INN providers should submit requests to:
Mail: PO Box 2092 Jersey City, NJ 07303 Fax:
1-888-240-7243
Secure Email: PO_Box_2092@cloverhealth.com

OON providers should submit requests to:
Mail: PO Box 2091 Jersey City, NJ 07303
Fax: 1-732-412-9706
Secure Email: PO_Box_2091@cloverhealth.com

*Please provide good cause 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