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 #: ( )

Contact 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: 1-888-740-8243 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