

**A.R.S §36-2903.01 ((B)(4) and Arizona Administrative Code R9-34-405 state in part:**

All claim disputes (i.e. a dispute involving payment or denial of a claim) must be submitted in writing within 12 months from the date of service (or the date of discharge for an inpatient claim), within 12 months from the date of eligibility posting, or within 60 days of the last adverse action, whichever is greater.

**Claim Dispute requests must include:**

1. A completed Claim Dispute Form **OR** a letter detailing the factual and legal basis for your dispute (please use one form for each disputed claim);
2. A copy of the original claim and remittance advice;
3. Disputes with a clinical component (such as denied inpatient days, services denied for lack of medical necessity, claims denied for lack of prior authorization, etc.) should include a narrative describing the relief requested and all relevant medical records;
4. Mail the completed form(s) and documentation to:

**Claim Disputes**  
**Phoenix Health Plan**  
**7878 N. 16<sup>th</sup> St. #105**  
**Phoenix, AZ 85020**

Your dispute will be acknowledged within five (5) working days. You will receive a written Notice of Claim Dispute Resolution explaining our decision within thirty (30) calendar days. PHP may request an extension of up to fourteen (14) additional days if necessary. Payment for approved disputes will also be displayed on the remittance advice. If you disagree with our resolution, you may request a hearing as per the guidelines in A.A.C. R9-22-405(D).

**NOTE:**

**Disputes that fail to detail the facts of the case as well the legal argument OR disputes submitted with incomplete information may be denied without medical review. PHP will not attempt to solicit supporting documentation.**

**Provider Information:**

Date:	Contact Name:
Provider Requesting Review:	F#:
Provider of Disputed Service (if different):	
Billing Address:	Phone Number:

**Member Information:**

Member Name:	Date of Birth:	AHCCCS I.D.:
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**Claim Information:**

Claim #:						
Date of Service:						
Procedure Code(s) disputed / Amt Billed & Pd for Each:						
Diagnosis Code(s):						

**Reason/Supporting Information for Dispute/Reconsideration:**

 Clinical Documentation Attached  Yes  No