INSTRUCTIONS: The Contractor shall utilize the instructions listed on this page to assist with completing Attachment A.

PROVIDER/COMPLAINANT

PROVIDER/COMPLAINANT NAME: LEGAL NAME OF THE PERSON/ENTITY WHO PROVIDED THE SERVICE AS REGISTERED WITH AHCCCS

TYPE (MD, DO, PA, ETC.): MEDICAL DR, HOSPITAL, INPATIENT FACILITY ETC.

AHCCCS PROVIDER ID: SIX DIGIT NUMBER THAT AHCCCS ASSIGNED TO THE PROVIDER WHEN APPROVED FOR ENROLLMENT WITH AHCCCS TO PROVIDE SERVICES.

PHONE NUMBER: ACTIVE PROVIDER TELEPHONE NUMBER

ADDRESS: PROVIDER ADDRESS SHOULD MATCH WHAT THE PROVIDER HAS USED TO REGISTER WITH AHCCCS (PROVIDER ID) AND CORRESPOND WITH THE PERSON/ENTITY PROVIDING SERVICE.

COMPLAINANT HEARING REPRESENTATIVE

HEARING REPRESENTATIVE: WHO WILL BE REPRESENTING THE PROVIDER/COMPLAINANT AT THE HEARING. THIS IS TYPICALLY THE CONTACTED PERSON/ENTITY WHO REQUESTED THE HEARING. COULD BE A BILLING REPRESENTATIVE OR AN ATTORNEY.

PHONE NUMBER: ACTIVE TELEPHONE NUMBER

ADDRESS: ADDRESS TO WHICH LEGAL DOCUMENTS INCLUDING THE NOTICE OF HEARING WILL BE SENT

CLAIM DISPUTE

DATE(S) OF SERVICE: DATE SERVICES WERE PROVIDED. CAN BE A SINGLE DATE OR A RANGE (IF RANGE, PLEASE LIST IN CHRONOLOGICAL ORDER WITH EARLIEST DATE FIRST: EXAMPLE: 01/01/2023 TO 12/01/2023. DO NOT LIST AS 12/01/2023 TO 01/01/2023.)

BILLED AMOUNT: $ TOTAL DOLLAR AMOUNT BILLED VIA THIS CLAIM DISPUTE

CLAIM DISPUTE ISSUE CATEGORY: WHY WAS THE CLAIM DISPUTED? EXAMPLE: MEDICAL NECESSITY

ISSUE TO BE HEARD AT HEARING: WHAT IS THE ISSUE THE PROVIDER IS REQUESTING THE COURT HEAR. EXAMPLE: WERE THE SERVICES PROVIDED MEDICALLY NECESSARY?

LEGAL CITATIONS: EXAMPLE: PURSUANT TO AAC R9-22-202(B)(1). "ONLY MEDICALLY NECESSARY, COST EFFECTIVE, AND FEDERALLY REIMBURSABLE AND STATE-REIMBURSABLE SERVICES ARE COVERED SERVICES."

Effective Dates: 04/18/17, 10/01/18, 01/25/19, 06/13/23, 08/13/24
Approval Dates: 05/30/18, 01/11/19, 05/11/23, 08/08/24

CONTRACTOR DISPUTE NUMBER: THE HEALTH PLANS ASSIGNED DISPUTE NUMBER.

MEMBER INFORMATION

MEMBER NAME: MEMBER THAT SERVICES WERE PROVIDED TO

MEMBER'S AHCCCS ID NUMBER: MEMBER'S AHCCCS ID NUMBER

EXPEDITE: ☐Yes ☐ No

**End of instructions.*

PROVIDER/COMPLAINANT

PROVIDER/COMPLAINANT NAME: _____ TYPE (MD, DO, PA, ETC.): _____

AHCCCS PROVIDER ID: _____ PHONE NUMBER: _____

ADDRESS: _____

COMPLAINANT HEARING REPRESENTATIVE

HEARING REPRESENTATIVE: _____

PHONE NUMBER: _____ ADDRESS: _____

CLAIM DISPUTE

DATE(S) OF SERVICE: _____ BILLED AMOUNT: $ _____

CLAIM DISPUTE ISSUE CATEGORY: _____

ISSUE TO BE HEARD AT HEARING: _____

_____

_____

LEGAL CITATIONS:

_____

CONTRACTOR DISPUTE NUMBER: _____

MEMBER INFORMATION

MEMBER NAME: _____ MEMBER'S AHCCCS ID NUMBER: _____

EXPEDITE: ☐Yes ☐ No