Provider Dispute Resolution Request

FOR USE WITH MULTIPLE "LIKE" CLAIMS (Claims disputed for the same reason)

Western Health Advantage

	*Patient Last Name	*Patient First Name	Date of Birth	*Health Plan ID#	Original Claim ID#	*Service From/ To Date	Original Claim Amount Billed	Original Claim Amount Paid
1								
2								
3								
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9								
10								
11								
12								
13								
14								
15								

❑ Check here if additional information is attached (please do not staple)

WHA Provider Dispute Resolution Request: Multiple Claims | ICE Approved 10.05.07, effective 01.01.08 | Last reviewed or revised by WHA: 12.16