# Provider Claim Dispute Form

Select Health of South Carolina

A **dispute** is defined as a request from a health care provider to change a decision made by Select Health of South Carolina related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

| **Submitter/Contact information** | | |
|---|---|---|
| Name (Last, First) | Submission date | Phone |

| **Provider information** | | |
|---|---|---|
| Provider name (Last, First) | NPI # | Tax ID # |
| Phone | ☐ I am a participating provider ☐ I am **not** a participating provider. | |

| **Member information** | | |
|---|---|---|
| Member name (Last, First) | Date of birth | Member ID# |

| **Claim information** | | |
|---|---|---|
| Claim number | Billed amount | Date(s) of service(s) |
| Claim number | Billed amount | Date(s) of service(s) |
| Claim number | Billed amount | Date(s) of service(s) |
| Claim number | Billed amount | Date(s) of service(s) |

**Attach additional sheets if necessary.**

| **Payment Dispute Section** To ensure timely and accurate processing of your request, please check the applicable reason below for your dispute. | |
|---|---|
| ☐ Inaccurate payment | ☐ Denied for no primary payer EOB (EOB attached) |
| ☐ Post-service authorization denial | ☐ Denied for no authorization (service does not require authorization) |
| ☐ Denied as a duplicate | ☐ Denied for no authorization (auth. # on file) |
| ☐ Clinical edit limitation or denial | ☐ Untimely filing (proof of timely filing attached) |
| ☐ Other: | |
| Additional information: | |

Please mail this completed form and any supporting documentation to:

**Select Health of South Carolina**
**Provider Claims Disputes**
**P.O. Box 7310**
**London, KY 40742-7310**