



Provider Administrative Review Form

DirectProvider.com is the preferred method for submitting claim reviews.

Submit your dispute within 35 days of your receipt of the Remittance Advice.

Product: <input type="checkbox"/> Commercial/Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Healthy Kids <input type="checkbox"/> Long Term Care	
Reason: <input type="checkbox"/> Incorrect Claims Payment <input type="checkbox"/> Medical Appeal <input type="checkbox"/> Reconsideration	
Request: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third	Claim Number: _____

MEMBER INFORMATION

Date of request	Date(s) of Service
Member Name	Member ID#

PROVIDER INFORMATION

Provider Name	Tax ID
Contact Name	Phone
Address	City, State, Zip Code

Attached: EOB RA Claim Medical Records Other: _____

Additional Information supporting your dispute:

SUBMIT DISPUTE TO:
Coventry Health Care of Florida
Claim Unit

For Medicare: P.O. Box 7808 London, KY 40742	For Medicaid/Healthy Kids: P.O. Box 7403 London, KY 40742	For Long Term Care: P.O. Box 7403 London, KY 40742	For Commercial: P.O. Box 7807 London, KY 40742
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Submission Guidelines:

- § One Claim Reconsideration Form should be used for each claim denial, reconsideration, and appeal
- § If submitting multiple claims for reconsideration, one form will be accepted per reason for review
- § Please include medical records for the dates of service under review
- § Hospitals appealing the denial of inpatient services must submit complete medical records for the member's entire length of stay, including physicians' orders, progress notes, therapy notes, and ER records, as applicable
- § The Provider Manual should be used as a resource for guidelines related to claim reconsiderations, denial and appeals ([available at www.directprovider.com](http://www.directprovider.com))