INTERNAL DISPUTE RESOLUTION REQUEST FORM

Date: _____

Claim Number: _____ Policyholder Name: _____

Date of Loss: _____ Claim representative: _____

Provider

Name: _____

Address: _____

Telephone: _____ Fax: _____

Provider Attorney (if applicable)

Name: _____

Address: _____

Telephone: _____ Fax: _____

Injured Party

Name: _____

Address: _____

Telephone: _____ Fax: _____

Injured party Attorney (If known: name, address, phone): _____

_____

Injury Information

Brief description of the injuries: _____

_____

_____

_____

Nature of dispute: _____

_____

_____

_____

_____

_____

Please select a reviewer from the enclosed panel of physicians. For a current list, please select a name from the panel provided at http://www.medlogix.com or contact State Farm.

Name: _____

Have you executed a State Farm Conditional Assignment of Benefits? ☐ No ☐ Yes
(*If yes, please attach copy of Assignment of Benefits)*

Dispute Type (Check all that apply):

☐ Medical Necessity of treatment/testing/services

☐ Relationship of injury/treatment/testing/services to Motor Vehicle Accident

Date(s) of Service	Date Bill Submitted to State Farm	Amount in Dispute

Filing Instructions

Please send an original and one (1) copy of this Internal Dispute Resolution Request Form with copies of supporting information to:

State Farm
PO Box 696044
San Antonio, TX 78269-6044

OR

Fax: (866) 497-2745

Signature: _____

Date: _____

A copy of the independent reviewer's determination will be sent directly to you.

The Internal Dispute Resolution process is non-binding.

The decision may be rejected in writing by either party.

If you have a properly executed State Farm Conditional Assignment of Benefits, you may be required to complete this process prior to accessing PIP Dispute Resolution in accordance with State Farm automobile policy and as set forth in NJAC 11:3-5 and NJ Law.