

## Claims Liaison Dispute Submission Request Form

|          |  |
|----------|--|
| Send To: | <a href="mailto:claimsliaison@usamco.com">claimsliaison@usamco.com</a> |
| Company: | USA SENIOR CARE NETWORK  |
| Fax:     | 512-306-7073   |
| From:    |  |
| Company: | Arkansas Blue Cross and Blue Shield                                    |
| Phone:   |  |
| Fax:     |  |
| Date:    |  |

Client / Group Name: Arkansas Blue Cross and Blue Shield

- Verify PPO Status     
  Duplicate Statement     
  Verify Discount  
 Provider Balance Billing     
  Provider Disputing Discount     
  Provider Disputing Participation

### Dispute Description:

Facility Name: \_\_\_\_\_  
 Facility TIN: \_\_\_\_\_  
 Facility Service Address: \_\_\_\_\_  
 Patient First and Last Name: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Patient DOS: \_\_\_\_\_  
 Patient Hospital Acct #: \_\_\_\_\_  
 Patient Home Address: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 EOB Attached? Yes  No   
 Misc. Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*\*\* Please include copy of the EOB(s) if applicable\*\*\***

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