Claims Liaison Dispute Submission Request Form

Send To:	claimsliaison@usamco.com
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*****

Confidentiality Notice: Confidential Health Information Enclosed

Protected Health Information (PHI) is personal and sensitive information related to a person's health care. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/client consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.

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