



**Instructions**

If you have not previously addressed this issue with Oscar, please call 855-OSCAR-55 to speak with a representative. This matter should undergo a preliminary review before filing a dispute.

Filling out this completed form will constitute a provider initiating a formal Dispute with Oscar and will trigger Oscar's Dispute Resolution Process.

Please complete this form and mail to:

Oscar Garden State Insurance Corporation  
P.O. Box 52146  
Phoenix, AZ 85072-2146

Please call Oscar at 855-OSCAR-55 if you want to check on the status of your dispute.

**Provider Information - Fill out all fields.**

Provider Type	<input type="radio"/> Physician	<input type="radio"/> Anxilliary	<input type="radio"/> Hospital	<input type="radio"/> Ambulatory Surgical Center
	<input type="radio"/> Ambulance	<input type="radio"/> Home Health	<input type="radio"/> Rehabilitation Center	<input type="radio"/> Durable Medical Equipment
	<input type="radio"/> Assisted Living Facility			
	<input type="radio"/> Other (Please specify): _____			
Provider Name	Provider NPI		Provider Tax ID Number	
Provider Address	Suite/FL #	City	County	State
				Zip code
Phone	Fax		Email address	

**Dispute Type - Choose one.**

Dispute Type	<input type="radio"/> Contracted rate	<input type="radio"/> Timely filing	<input type="radio"/> Benefits decision	<input type="radio"/> Out-of-network review
	<input type="radio"/> Claims messages	<input type="radio"/> Prompt payment	<input type="radio"/> Health plan refund request	<input type="radio"/> Request for additional information
	<input type="radio"/> Other (Please specify): _____			

**Disputed Claim Information - Include the following information about the claim in dispute.**

Patient Name	Patient's Oscar ID Number	Claim ID
Dates of service		

**Dispute Description**

Check here if supporting documentation is enclosed.  
Please be specific about how you would like this be resolved: