Claims Disputes Provider Form

Claims disputes must relate to a claim determination made by Oscar. *If you are appealing the outcome of an authorization, whether pre-service, concurrent, or post-service, use the* ***Clinical Appeals*** *Provider Form. If you are submitting a claims-related document (e.g., medical record, itemized bill) that is not a dispute or appeal, use the* ***Claims-Related Documents*** *Provider Form.*

Provider information		
First name	Last name	
Provider NPI	Group NPI	Provider TIN
Facility / Group Name	Are you contracted with Oscar? ◯ Yes ◯ No	
Contact phone #	Contact fax #	

Member information (one member only)	
First name	Last name
DOB	Member Oscar ID (OSC#xxxxxxxx-xx)

Claim information (one claim ID only)		
Oscar claim ID	DOS Start	DOS End
Billed amount	Procedure code(s)	

Select one dispute category	
◯ Pre-certification/authorization not obtained (*please attach medical records to enable clinical review*) *Auth ID, if auth not matched to claim:* _____	
◯ Pricing due to contract, fee schedule, or reimbursement policies	◯ Refund / stop payment *(requesting retraction of entire payment or service line)*
◯ Duplicate claim (incl. duplicate lines on a claim)	◯ Coordination of benefits review
◯ Payment edits: _____	◯ Exceeded claim timely filing limit
◯ HMO Referral *Referral ID, if obtained:* _____	◯ Document submission deadline
◯ Benefits and costshare (*copay, deductible, labs*)	◯ Member eligibility (*inactive policy, gap in coverage, effectuation*)
◯ Out of network review (*surprise bill / emergent / SCA / LOA)*	◯ Benefit plan exclusion or limitation

Explanation (state the reason for the dispute, and expected outcome, below)

Supporting documentation (please list what documents you've attached as supporting documentation)

Please send your completed form and supporting documentation via one of the following methods:

- Fax: 1-888-977-2062
- Mail: Oscar Health, Inc. P.O. Box 52146 Phoenix AZ, 85072–2146.