



Participating Provider Dispute Form

Date: _____

Member Information	
Member Last Name:	
Member First Name:	
Date of Birth:	
Member Identification Number:	

Provider/Facility Information	
Contact Name:	
Phone Number (with area code):	
Fax Number (with area code):	
Email Address:	
Provider First and Last Name: (as listed on Evidence of Payment "EOP")	
Facility/Group Affiliation: (as listed on Evidence of Payment "EOP")	
Street Address:	
City, State, Zip Code:	
NPI Number:	
Tax ID Number:	

Reason for Request	
Date of Service:	
Claim #:	
CPT Code(s):	
Total Charges:	
Expected Amount:	

<input type="checkbox"/>	Denied - "Exceeds Timely Filing"
<input type="checkbox"/>	Denied - Requesting additional information
<input type="checkbox"/>	Denied - "Coordination of Benefits"
<input type="checkbox"/>	Resubmission of corrected claim – Submit Electronically
<input type="checkbox"/>	Previously adjudicated but applied incorrect rate, resulting in over/underpayment
<input type="checkbox"/>	Denied for "no authorization"
<input type="checkbox"/>	Other (provide details below)

Comments – Reason for Dispute

Please include the following: (1) a copy of the initial claim (2) a copy of the EOP (3) all other documents supporting the request for dispute.

Submission Options: (1) Email: provider.services@myzinghealth.com (2) Fax: 844-918-4458 (3) Mail to:

ATTN: Provider Disputes
Zing Health, Inc.
225 W Washington St Suite 450
Chicago, IL 60606