APPEAL / CLAIM PAYMENT DISPUTE COVER SHEET

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	☐ Provider ☐ Organization Representing Provider ☐ Appointment of Representative (attach form) ☐ Other (Summarize)
	Name of Organization Representing Provider	
1.3	Submitter's Name	
	E-mail Address	
	Telephone Number	
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	
1.6	Provider Name, telephone number, E-Mail address	
1.7	Medicare Advantage Organization	
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	☐ Provider Contracted with MAO during Date(s) of Service ☐ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	☐ Contracted Provider Appeal ☐ Non-Contracted Provider Appeal ☐ Contracted Provider Claims Payment Dispute ☐ Non-Contracted Provider Claims Payment Dispute Other
	Brief Summary of Complaint	
1.12	Did MAO communicate your appeal rights.	☐ Yes ☐ No
1.13	Have you exhausted all appeals rights per the non- contracted provider appeals or per contract w/MAO	☐ Yes ☐ No

1.14	Provider or their representative has Communicated with MAO in Attempt to Resolve Issue	☐ Yes ☐ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*
	If Yes, Name(s) of Individual(s) at MAO	