COVENTRY
Health Care of Florida
VISTA • SUMMIT • ADVANTRA

Provider Administrative Review Form

DirectProvider.com is the preferred method for submitting claim reviews.

Submit your dispute within 35 days of your receipt of the Remittance Advice.

Product: ☐ **Commercial/Individual** ☐ **Medicare** ☐ **Medicaid** ☐ **Healthy Kids** ☐ **Long Term Care**	
Reason: ☐ **Incorrect Claims Payment** ☐ **Medical Appeal** ☐ **Reconsideration**	
Request: ☐ **First** ☐ **Second** ☐ **Third**	**Claim Number:**_____

MEMBER INFORMATION	
Date of request	Date(s) of Service
Member Name	Member ID#
PROVIDER INFORMATION	
Provider Name	Tax ID
Contact Name	Phone
Address	City, State, Zip Code

Attached: ☐ EOB ☐ Claim ☐ RA ☐ Medical Records ☐ Other: _____

Additional Information supporting your dispute:

SUBMIT DISPUTE TO:
Coventry Health Care of Florida
Claim Unit

For Medicare:	**For Medicaid/Healthy Kids:**	**For Long Term Care:**	**For Commercial:**
P.O. Box 7808 London, KY 40742	P.O. Box 7403 London, KY 40742	P.O. Box 7403 London, KY 40742	P.O. Box 7807 London, KY 40742

Submission Guidelines:

- § One Claim Reconsideration Form should be used for each claim denial, reconsideration, and appeal
- § If submitting multiple claims for reconsideration, one form will be accepted per reason for review
- § Please include medical records for the dates of service under review
- § Hospitals appealing the denial of inpatient services must submit complete medical records for the member's entire length of stay, including physicians' orders, progress notes, therapy notes, and ER records, as applicable
- § The Provider Manual should be used as a resource for guidelines related to claim reconsiderations, denial and appeals (available at www.directprovider.com)