



M•Plan Provider Claim Dispute Form

For routine inquiries, please check status at mplan.com.

Date of Inquiry: ____ / ____ / ____

Provider Group Name: _____

Provider Phone #: (____) _____

Contact Name: _____

Return FAX #: (____) _____

**FAX to:
(317) 580-4706**

•••••••• **Please do not use this form for Clinical Edit Appeals** ••••••••

1.

Patient Name	DOB	M•Plan ID#	DOS	Amount Billed	Patient Account #
	/ /		/ /	\$.	
Provider Notes:					
M•Plan Response:					

2.

Patient Name	DOB	M•Plan ID#	DOS	Amount Billed	Patient Account #
	/ /		/ /	\$.	
Provider Notes:					
M•Plan Response:					

- **Dispute response time** is within 1 week.
- **Routine inquiry response time** (if faxed on this form) is between 3 and 6 weeks.
- **My M•Plan 24/7 inquiry response time** is instantaneous.