

Please complete all areas of this form and attach all appropriate documentation as well as a typed letter stating the reason why you believe the coverage denial was incorrect. Detailed descriptions of information required to process a provider dispute are located in the [CareLink Provider Payment Dispute Policy](#).

Today's date: \_\_\_\_\_

<b>Member Identification Number and Suffix:</b>	
<b>Member Name:</b>	
<b>Date of Birth:</b>	
<b>Date(s) of Service:</b>	
<b>Procedure/Type of Service:</b>	
<b>Provider Name:</b>	
<b>Contact Number:</b>	
<b>Email Address:</b>	
<b>Phone Number:</b>	
<b>Claim Number:</b>	
<b>Provider ID# (Internal Use Only)</b>	

Disputes should be mailed to the following address:

Tufts Health Plan<sup>®</sup>  
 CareLink<sup>SM</sup> - Shared Administration  
 Attn: Provider Payment Disputes  
 P.O. Box 9165  
 Watertown, MA 02471-9165

The following is a list of required documentation  
**(check and submit all that apply):**

- Corrected Claim
- Invoice Attached
- Office Notes Attached
- Operative Notes Attached
- Proof of Timely Filing
- Radiology/Pathology Report(s)
- SOA/EOB with Claim Circled
- Typed Letter of Medical Necessity Explaining Why the Service was Necessary