CareLink[SM] – Shared Administration Provider Payment Dispute Form

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: _____

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

Disputes should be mailed to the following address: Tufts Health Plan CareLink[SM] – 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

Provider Services