Health Plans

IU Health Plans Commercial
Provider Claim Dispute Form

Fax form to:
Provider Services
(317) 968-1205

Date of Inquiry: ____/____/____

Provider Group Name: _____

Provider Phone Number: _____

Contact Name: _____

Return Fax Number: _____

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

Patient Name	DOB	Member ID#	DOS	Amount Billed	Claim #
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Provider Notes:

IUHP Response:

Please submit the appropriate documentation where applicable.
Dispute response time is within 20 days. Routine inquiry response time (if faxed on this form) is between 2-4 weeks.