Contracted Provider Dispute Form

Directions: If you wish to dispute a decision, please fill out the required information below and mail or fax this form to the address/fax number shown below. Please include a copy of your claim, explanation of payment, and medical records.

Submit all Claims Disputes to our Claims Department:

Attn: Claims Department/Claim Dispute
Leon Health, Inc.
PO Box 668230
Miami, Fl 33166
Fax: (305)718-2870

Member Information			
Member Name			
Member ID			
Disputing Provider Information			
Provider Name			
Provider NPI or Tax ID			
Address of Provider	Street:		
	City:	State:	Zip Code:
Phone Number	( )		
E-mail Address			

Claim Information	
Claim Number(s)	
Item or Service you wish to dispute	
CPT Code(s)	
ICD10 Code(s)	
Date(s) of Service	
Describe the reason(s) for your dispute	
Type of supporting documentation	☐ Authorization ☐ Explanation of Payment ☐ Proof of Timely Filing ☐ Medical Records ☐ Other: _____

_____ _____

Signature of Provider Disputing the Claim Date

H4286_CLAIMSPRVDISPUTE_22_C