Readmission Dispute Form

First Level Dispute Second Level Dispute
(please select one)

Please submit this form and both required medical records to:
Readmissions@mdwise.org

Facility/Provider Name:________________________ Date: ________________________

Telephone Number:________________________ Email: ________________________

Member Name:________________________ Date of Birth: ________________________

Date of Service:________________________ Member ID #: ________________________

Billed Amount:________________________ Claim #: ________________________

MDwise Program: Hoosier Healthwise HIP
(please select one)

Describe disputed claim. Description should include, but not be limited to the following items: Medical Reason 2nd claim should be considered, medical records for both admissions, claim date of service and claim number for both admissions.

Form Completed By *(please print)*:

________________________ Date:________________________

If you are unable to email, please mail them to the following address:
MDwise/McLaren Claims
PO Box 441423
Indianapolis, IN 46244-1423
Attn: Readmission Disputes

Please provide correspondence address:

____

____

____

HHW-HIPP0627 (10/22)