SECTION 1011 DISPUTE RESOLUTION REQUEST

DIRECTIONS: If you wish to request a dispute resolution on a payment request determination, please fill out this form and mail it, along with documentation, to:

TrailBlazer Health Enterprises, LLC
Attn: Section 1011 Dispute Resolution
P.O. Box 660529
Dallas, TX 75266-0529

NOTE: Failure to complete **ALL** the data elements on this form **and/or** failure to submit the necessary documentation will result in your request for a dispute resolution being dismissed. Disputes must be submitted no later than 45 days after the quarterly payment date for the quarter in which the disputed payment request was billed.

Provider Name			
Section 1011 Provider Identification Number (PIN)			
Patient Identifier Number (HIC)			
Document Control Number (DCN)			
Full date range of service			
Specific date(s) of items in dispute			
Original amount submitted for reimbursement			
Denied service and reason for dispute			
Requester's Name			Title
Requester's e-mail address			
Requester's mailing address	City	State	Zip Code
Requester's telephone number (include area code)			
Requester's signature			Date signed

☐ All documentation regarding dispute is attached.

☐ Letter of representation is attached (if requester is an entity other than the provider).

Please note that TrailBlazer will not send an acknowledgment of receipt and providers may not appeal finalized disputes. TrailBlazer will notify providers of decisions via e-mail.