



Request for Medicare Claims Dispute Form

Today's Date:		Health Plan Name: Heraya Health	
Provider Information			
Provider Name:		Contact Name:	
NPI #:		Contact Phone #:	
Member / Claim Information			
HRN#:		Member Name:	
Date (s) of Service (MM/DD/YY):			
Claim Number (s):			
*Medicare Claims Dispute Type			
Enter X in the box below to reflect the Medicare claims dispute type			
☐	Timely Filing		
☐	Other		
*Medicare Claims Dispute Explanation			
Where to Send Information			
Mail: Heraya Health, 6600 SW 105 th Avenue, Suite 115, Beaverton, OR 97008 Fax: 503-203-8522 For Questions call: 503-203-8333 <u>Fax or mail the following information to Heraya:</u> <ul style="list-style-type: none"> • Request for Medicare Claims Dispute Form • A copy of Heraya's Medicare Remittance Advice Denial • Supporting documentation reflecting the new information 			