Provider Dispute Request

Please provide the following information.

Date of Request	Member ID Number	Subscriber ID Number	Group Number

Member First Name	Member Last Name	Member DOB (MM/DD/YYYY)

Claim ID Number(s)	Authorization Number	Service Date(s)

Denial Notification Date(s)	Service(s) for Review (CPT and/or HCPCS and/or ICD and/or Revenue Code(s))

Explanation of Your Request (Please attach additional documentation if necessary.)

Provider Name	TIN/NPI	Provider Group (if applicable)

Provider Office Contact

Contact Address (for response)

Contact Phone	Contact Fax	Contact Email Address

Please submit supporting documentation including medical records, office notes or lab test results where available.

Mail your request to:

Oxbridge Health Inc.
PO Box 1413
Westborough, MA 01581

Or

Fax your request to:

+1 (469) 228-4268