ARBITRATION SUMMARY

Provider Name: _____

Patient Name: _____

Service Date Range: _____ to _____

Amount Billed: $_____._____

Amount Paid: $_____._____

Amount Adjusted: $_____._____

Amount Due: $_____._____ **(PLEASE BE SURE TO PROPERLY FEE SCHEDULE)**

Type of Service:

- ☐ Physical Therapy
- ☐ Diagnostic Testing
- ☐ Surgical Procedure
- ☐ Emergency / Hospital
- ☐ Office Visits
- ☐ Chiropractic
- ☐ Accupuncture
- ☐ Psychotherapy
- ☐ Medical Supplies
- ☐ Other _____

Reason for Denial:

- ☐ Peer Review
- ☐ No Carrier Response
- ☐ "Independent" Medical Exam
- ☐ Other _____

Denial Enclosed:

- ☐ YES
- ☐ NO

Other Documents Enclosed:

- ☐ Initial Report
- ☐ Assignment of Benefits*
- ☐ Letter of Medical Necessity
- ☐ Test Results
- ☐ ALL Bills in Dispute
- ☐ ALL Treatment Notes
- ☐ Medical Reports
- ☐ Rebuttal
- ☐ Other _____

* The provider name on the "Assignment of Benefits" form should match the provider name on all bills.