

**INTERNAL DISPUTE RESOLUTION REQUEST FORM**

Date:  
Claim Number:  
Date of Loss:  
Policyholder Name:  
Patient Name:

**Provider Information**

Provider Name:  
Contact Person:  
Street Address:  
City/State/Zip:  
Telephone Number:  
Fax Number:

**Provider Attorney (if applicable)**

Name:  
Street Address:  
City/State/Zip:  
Telephone Number:  
Fax Number:

**Patient Information:**

Name:  
Street Address:  
City/State/Zip:  
Telephone Number:  
Fax Number:

**Injury Information:**

Brief description of injuries (include diagnoses):

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