MDwise
A McLaren Company

1st Level Readmission Dispute Form

Please submit this form and required medical records to MDwiseclaims@McLaren.org.

Facility/Provider Name: _____ Date: _____

Telephone Number: _____ Email: _____

Member Name: _____ Date of birth: _____

Date of Service: _____ Member ID #: _____

Billed Amount: _____ Claim #: _____

MDwise Program: ◯ Hoosier Healthwise ◯ HIP
(please select one)

Describe disputed claim. Description should include, but not be limited to the following items: reason given for denial and position statement that explains why this claim should be paid.

Please attach medical records for review.

Form Completed By *(please print)*:

_____ Date: _____

If you are unable to email, please mail them to the following address:

MDwise/McLaren Claims
P.O. Box 1575
Flint, MI 48501
Attn: 1st Level Readmission Disputes

Please provide correspondence address:

_____

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