

# CCHP PROVIDER PORTAL APPEAL/DISPUTE PROCESS

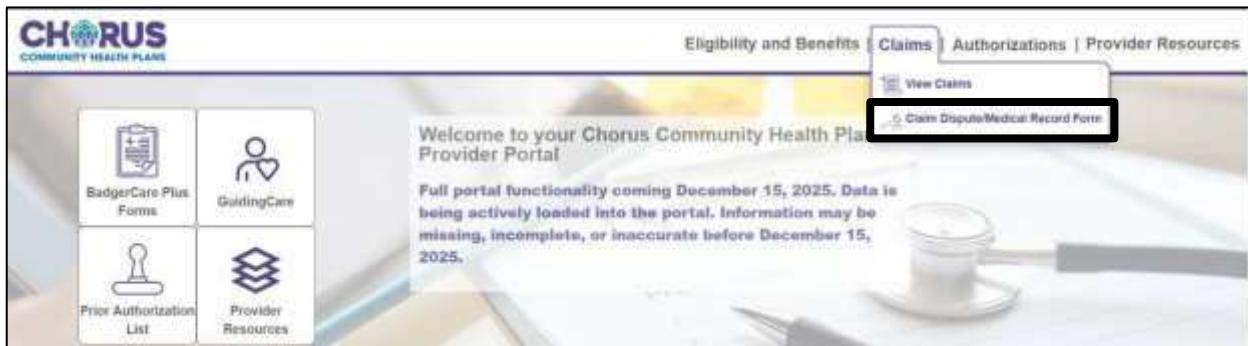
Providers have up to 365 days from the receipt of a partial payment, denial or a determination that is unsatisfactory to file an appeal.

Prior to submitting an appeal, contact Provider Customer Service at 877-458-1289 to assist in researching and resolving your claim.

## Instructions:

### [Login to the CCHP Provider Portal](#)

1. From the home page select the **Claims** tab from the navigation menu and click **Claim Dispute/Medical Record Form**.



2. Next, enter the claim number in the **Claim ID** box and click the **Search** button.
  - a. If the claim is within 365 days from the receipt of the claim determination (payment, denial etc.), the claim information will display in the **Results** section as **Selected**.
  - b. **Important Note:** To look up claims submitted before December 15, 2025, remove the first two digits ("20") from the claim number.  
You can also search for claims using the member ID.
    - *Example for claim number 20250714H123456, search 250714H123456*

3. Next, select the **Proceed to Step 2-Add Detail** button.

### Provider Dispute/Medical Records

[Submit a Dispute](#) [Submit Medical Records](#) [Previous Requests](#)

Search for a claim by entering the claim ID below.

Providers have up to 365 days from the paid date of the claim to file an appeal.

#### Search for Claims

Claim ID:

Search

#### Result

Claim ID	Name	Service Date	Amount
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REDACTED			
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Selected

#### Selections

Claim ID  
Patient  
Remove

Proceed to Step 2 - Add Detail

4. The final page auto populates the Claim ID, Patient Name, Date of Service and billed Amount.

- It is **required** for the user to:
  - Indicate if they are a Participating or Non-Participating Provider.
    - (Yes/No)
  - Provide an explanation for the dispute in the explanation box.
  - Attach documentation to support the dispute

5. When these steps are complete, the user will click **Submit Dispute**.

You will receive an email confirmation with the dispute number for tracking purposes.

**Add Provider Dispute Detail**

You have selected 1 claim to dispute. Add detail and attach all relevant documentation below. You must attach at least one document to the dispute. Fields marked with an asterisk are required. Click Submit Dispute to send your request to Chorus Community Health Plans.

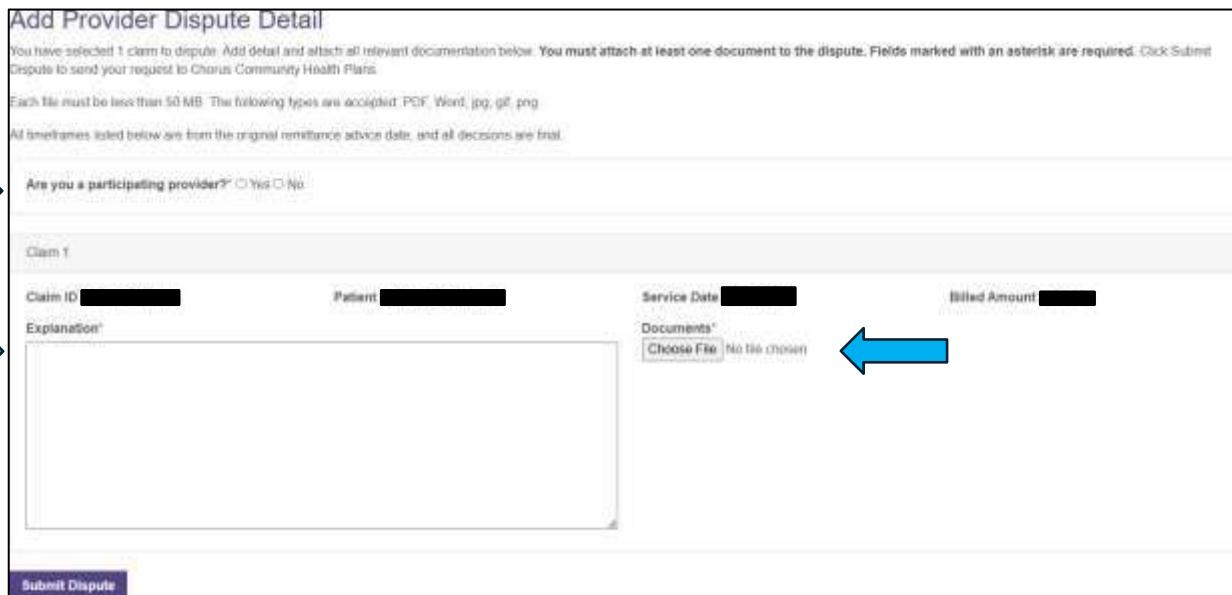
Each file must be less than 50 MB. The following types are accepted: PDF, Word, jpg, gif, png

All timeframes listed below are from the original remittance advice date, and all decisions are final.

Are you a participating provider?  Yes  No

Claim 1	Patient	Service Date	Billed Amount
Claim ID [REDACTED]	Patient [REDACTED]	Service Date [REDACTED]	Billed Amount [REDACTED]
Explanation:		Documents* <input type="button" value="Choose File"/> No file chosen	

**Submit Dispute**



6. Notifications:

- a. If the appeal is upheld a letter will be attached to appeal providing an explanation for that decision.
- b. If overturned, you'll see a notification when the claim is reprocessed via your remittance advice.