genex
Care for Oklahoma

DISPUTE RESOLUTION FORM

Person filing the dispute: Check One: ( ) Employee ( ) Provider ( ) Employer ( ) Insurer/Claims Admin
Before you complete this form, have you contacted your plan by phone or fax and discussed your complaint with a Certified Workplace Medical Plan representative at 800-248-4363?

Provide all information requested below and describe your dispute in detail on the space provided on the back of this form. Include dates, names, and the specific resolutions which you feel would remedy the situation. Mail this form to the address noted on the back of this form or fax it to **877-236-7382.** Attach additional pages or information if necessary.

EMPLOYEE INFORMATION

Name: _____

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Fax: (_____)_____

PROVIDER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

PPO Provider ☐ Yes ☐ No* *Authorized Family Physician: ☐ Yes ☐ No

EMPLOYER INFORMATION

Name: _____

Representative Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Fax: (_____)_____

INSURER/CLAIMS HANDLER INFORMATION

Name: _____

Representative Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Fax: (_____)_____

Care for Oklahoma

Signature _____ Date _____

Genex Care for Oklahoma
5830 NW Expressway, PMB364
Oklahoma City, OK 73132
Attention: CWMP Coordinator