



IMPROPER PAYMENT DISPUTE

TO: _____ - CLIENT SERVICES DEPARTMENT

FROM: _____

SUBJECT: PAYMENT DISPUTE

DATE: _____

Name of Child: _____

Date of Birth: _____

Social Security Number: _____

Month/Year Disputed: _____

Amount Disputed: _____ Money due to the Coalition Money due to the Provider

Dispute Explanation: _____

Supporting Documentation Attached:

- Copy of Attendance Roster for Disputed Time Period
- Copy of Sign In/Sign Out Sheet for Disputed Time Period
- Copy of Provider Reimbursement Transmittal for Disputed Time Period
- Excessive Absence Proof
- Other Documentation

Facility Name: _____

Provider Name (please print): _____

Provider Signature and Date: _____

Please note you have sixty (60) days from the receipt of the Reimbursement Transmittal to dispute an underpayment of services. If there is a payback due to the Coalition, the amount will automatically be withheld as a result of the EFS Reimbursement Process.

Client Services Department Only

Date Received: _____

Dispute Decision:

- Dispute Fully Awarded - complete ELCNC 234: Prior Period Adjustment
- Dispute Partially Awarded - Amount Awarded \$ _____ complete ELCNC 234: Prior Period Adjustment
- Dispute Denied

Explanation of award decision: _____

Client Services Counselor Name

Client Services Counselor's Signature

Date

Client Services Manager Name

Client Services Manager's Signature

Date