

## PROVIDER DISPUTE RESOLUTION REQUEST

**NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT**

### INSTRUCTIONS

- Please complete the below form. Fields with an asterisk ( \* ) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed, but please provide a corrected claim if applicable.
- Mail the completed form to: Notice of Provider Dispute Unit  
 P.O. Box 2460  
 Alameda CA 94501-4506

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / Medicare ID #:</b>
<b>PROVIDER ADDRESS:</b>	

**PROVIDER TYPE**     MD     Mental Health     Hospital     ASC     SNF     DME     Rehab  
 Home Health     Ambulance     Other \_\_\_\_\_  
(please specify type of "other")

**\* CLAIM INFORMATION**     Single     Multiple "LIKE" Claims (complete attached spreadsheet)    *Number of claims:* \_\_\_\_

<b>* Patient Name:</b>		<b>Date of Birth:</b>
<b>* Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)
<b>Service "From/To" Date:</b> ( * Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>

<b>DISPUTE TYPE</b>	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution of a Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request for Reimbursement of Overpayment	<input type="checkbox"/> Other:

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

<b>Contact Name (please print)</b>	<b>Title</b>	(    ) <b>Phone Number</b>
<b>Signature</b>	<b>Date</b>	(    ) <b>Fax Number</b>

[   ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**  
 (Please do not staple additional information)

*For Health Plan Use Only*

TRACKING NUMBER

PROVIDER ID#



## PROVIDER DISPUTE RESOLUTION REQUEST (For use with multiple “LIKE” claims)

**NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT**

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Page \_\_\_\_\_ of \_\_\_\_\_

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED  
(Please do not staple additional information)



# PROVIDER DISPUTE RESOLUTION REQUEST

## Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

### INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

<b>TRACKING NUMBER:</b>		<b>PROVIDER ID#:</b>	
<b>a. PROVIDER NAME:</b>		<b>b. CONTRACTED PROVIDER:</b> ____ YES ____ NO	
<b>c. DATE DISPUTE RECEIVED (Date Stamped):</b>		<b>d. DATE OF INITIAL PAYMENT OR ACTION:</b>	
<b>e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d)</b> ____ YES ____ NO (If NO, should be returned to provider without action)			
<b>f. DISPUTE TYPE:</b> <input type="checkbox"/> CLAIM ISSUE <input type="checkbox"/> OVERPAYMENT REIMBURSEMENT REQUEST <input type="checkbox"/> BILLING ISSUE <input type="checkbox"/> CONTRACT ISSUE <input type="checkbox"/> UM/MEDICAL NECESSITY ISSUE <input type="checkbox"/> OTHER _____ (Please specify type of "other")			
<b>g. DATE DISPUTE ACKNOWLEDGED:</b>		<b>h. TURNAROUND TIME (g – c):</b>	

**TYPE OF LETTER SENT:** (List the various ICE letters as applicable)

**IF NO ADDITIONAL INFORMATION REQUESTED:**

<b>j. DATE OF ACTION:</b>	<b>k. ACTION TURNAROUND TIME (j – c):</b>	<b>l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):</b>
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**IF ADDITIONAL INFORMATION REQUESTED:**

<b>m. DATE ADDITIONAL INFO REQUESTED:</b>		<b>n. TURNAROUND TIME (m – c):</b>	
<b>o. DATE ADDITIONAL INFO RECEIVED:</b>		<b>p. RECEIPT TURNAROUND TIME (o – m):</b>	
<b>q. DATE OF ACTION:</b>	<b>r. ACTION TURNAROUND TIME (q – o):</b>	<b>s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):</b>	

**COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:**

**ACTION (If decided in whole or part on behalf of provider, apply appropriate interest to payment or partial payment and make payment within 5 days of issuing determination):**