PROVIDER DISPUTE RESOLUTION REQUEST

| 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. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service. For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form. Mail the completed form to: Provider Disputes P.O. Box 23076 San Diego, CA 92193-3076 | | | | | | | | | | |
|---|-------------------------|--|---|-----------------|--|--|--|--|--|--|
| *PROVIDER NPI: | | PROVIDER TA | V ID. | | | | | | | |
| *PROVIDER NAME: | | FROVIDENTA | A ID . | | | | | | | |
| PROVIDER NAME. | | | | | | | | | | |
| PROVIDER ADDRESS: | | | | | | | | | | |
| PROVIDER TYPE MD Mental Health Professional Mental Health Institutional 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: | | | | | | | | | | |
| * Patient Name: | Date of Birt | Date of Birth: | | | | | | | | |
| * Health Plan ID Number: | Patient Account Number: | | Original Claim ID Number: (If multiple claims, use attached spreadsheet) | | | | | | | |
| Service "From/To" Date: (* Required for Cla Reimbursement Of Overpayment Disputes) | Original Claim | I Claim Amount Billed: Original Claim Amount Paid: | | | | | | | | |
| DISPUTE TYPE Seeking Resolution Of A Billing Determination Claim Seeking Resolution Of A Billing Determination Appeal of Medical Necessity / Utilization Management Decision Contract Dispute Disputing Request For Reimbursement Of Overpayment Other: | | | | | | | | | | |
| | r Overpayment | L | | | | | | | | |
| * DESCRIPTION OF DISPUTE: | | | | | | | | | | |
| EXPECTED OUTCOME: | | | | | | | | | | |
| | | | | | | | | | | |
| Contact Name (please print) | Title | | Ph (| one Number) | | | | | | |
| Signature | Date | | Fa | x Number | | | | | | |
| [] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple) HICE Approved 10/5/07, reviewed 8/1/23 | TRACKING NUM | BER | | _ PROV ID# | | | | | | |

PROVIDER DISPUTE RESOLUTION REQUEST For use with multiple "LIKE" claims (claims disputed for the same reason)

| | * Patient Name | | | | | | | |
|----|----------------|-------|------------------|----------------------------|--------------------------|---------------------------|---------------------------------|-------------------------------|
| | Last | First | Date of Birth | * Health Plan ID Number | Original Claim ID Number | * Service From/To Date | Original Claim Amount Billed | Original Claim Amount Paid |
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[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple) HICE Approved 10/5/07, reviewed 8/1/23