Provider Dispute Resolution Request

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Attention: Provider Dispute Resolution
Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

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 this Provider Dispute Resolution Form.

PROVIDER INFORMATION

*Provider NPI# ____________________ Provider Tax ID# ____________________

*Provider Name ____________________

Address ____________________ Suite # __________

City, State, Zip ____________________ Phone __________

Provider Type ❏ MD ❏ Mental Health Professional ❏ Mental Health Institutional ❏ Hospital ❏ ASC ❏ SNF ❏ DME ❏ Rehab
❏ Home Health ❏ Ambulance ❏ Other (please specify) ____________________

CLAIM INFORMATION

❏ Single ❏ Multiple "LIKE" Claims (complete attached spreadsheet) Number of Claims __________

*Patient First Name ____________________ *Last Name ____________________ MI ______

Date of Birth ____________________ *Health Plan ID# ____________________

Patient Account # ____________________ Original Claim ID# ____________________
(If multiple, use spreadsheet)

Service "From/To" Date: (*Required for Claim, Billing and Reimbursement of Overpayment Disputes) __________

Original Claim Amount Billed __________ Original Claim Amount Paid __________

Dispute Type ❏ Claim ❏ Appeal of Medical Necessity/Utilization Management Decision
❏ Seeking Resolution of a Billing Determination ❏ Contract Dispute
❏ Disputing Request for Reimbursement or Overpayment ❏ Other __________

*Description of Dispute ____________________
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Expected Outcome ____________________
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Print Name ____________________ Title ____________________

Signature ____________________ Date __________

Phone ____________________ Fax ____________________

❏ Check here if additional information is attached (please do not staple)

OFFICE USE ONLY Tracking # __________ **Prov. ID#** __________ **Contracted ❏ Yes ❏ No**

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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.

Tracking # ______________________________ Provider ID or NPI # ______________________________

a. Provider Name ______________________________ b. Contracted Provider ❑ Yes ❑ No

c. Date Dispute Received (Date Stamped) ______________ d. Date of Intitial Payment or Action ______________

e. Was Dispute Received Within Timeframe? (c–d) Yes No (If No, should be returned to provider without action)

f.1. Dispute Type ❑ Claim ❑ Appeal of Medical Necessity/UM Decision ❑ Billing Determination ❑ Overpayment Dispute ❑ Contract Dispute ❑ Other (Please specify) ______________________________

f.2. Provider Type ❑ Professional ❑ Institutional ❑ Other

g. Date Dispute Acknowledged ______________ h. Turnaround Time (g–c) ______________

TYPE OF LETTER SENT List the various ICE letters as applicable

If no additional information requested:

j. Date of Action ________ k. Action Turnaround Time (j–c) ________ l. Type of Action Upheld Overturned Other

If additional information requested:

m. Date Additional Info Requested ______________ n. Turnaround Time (m–c) ______________

o. Date Addition Info Received ______________ p. Receipt Turnaround Time (o–c) ______________

q. Date of Action ________ r. Action Turnaround Time (q–o) ________ s. Type of Action ❑ Upheld ❑ Overturned ❑ Other

Complete description of determination rationale ______________________________

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