

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: PCMG- SAN LUIS OBISPO or Fax to: (805) 918-4100
PO BOX 51840
Oxnard, CA 93031
- E-mail to: PDR.identitymso@commonspirit.org

*PROVIDER NPI:	PROVIDER TAX ID:
*PROVIDER NAME:	
PROVIDER ADDRESS:	

PROVIDER TYPE MD Hospital ASC SNF DME Rehab Ambulance
 Other _____

(please specify type of "other")

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

* Patient Name:		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 Claim, Billing, and Reimbursement Of Overpayment Disputes)		Original Claim Amount Billed:	Original Claim Amount Paid:
DISPUTE TYPE <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment		<input type="checkbox"/> Seeking Resolution of A Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Other:	

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

_____ **Contact Name (please print)** _____ **Title** _____ **Phone Number**

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

Signature _____

Date _____

()
Fax Number _____

<i>For Health Plan/RBO Use Only</i>	
TRACKING NUMBER _____	PROV ID# _____
CONTRACTED _____	NON-CONTRACTED _____

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For use with multiple "LIKE" claims (claims disputed for the same reason)

	* 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
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)
ICE Approved 10/5/07, effective 1/1/08

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)