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-SANTA MARIA
  PO BOX 51840
  Oxnard, CA 93031
  or Fax to: (805) 918-4100
  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

- ☐ Claim
- ☐ Appeal of Medical Necessity / Utilization Management Decision
- ☐ Disputing Request for Reimbursement of Overpayment
- ☐ Seeking Resolution of A Billing Determination
- ☐ Contract Dispute
- ☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

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

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

(Please do not staple)
ICE Approved 10/5/07, effective 1/1/08

Signature	Date	( ) Fax Number

For Health Plan/RBO Use Only

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)**

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Tracking Form

(For Optional Use by Health Plan/Delegated Provider)