

PROVIDER DISPUTE RESOLUTION REQUEST

- 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 dispute.
 - SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT
- MAIL THE COMPLETED FORM TO: Quality Care IPA/ Appeals and PDR Unit
17215 Studebaker Rd # 331
Cerritos CA 90703
Phone: 562 287 8887

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

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:* ___

* 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"/> 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:		

Contact Name (please print)	Title	()
		Phone Number
Signature	Date	()
		Fax Number

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

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

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(For use with multiple "LIKE" claims)

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

Number	*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	Expected Outcome
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 additional information)

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(6/2013)