



**PROVIDER DISPUTE RESOLUTION REQUEST**

**(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)