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:

Physician Healthcare Integration IPA/ Appeals and PDR Unit
6800 Lincoln Ave, Suite 200
Buena Park, CA 90620
Phone: 714 495 4392

*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:

☐ Claim
☐ Appeal of Medical Necessity/Utilization Management Decision
☐ 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**

_____ _____ (____)_____

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#

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)

(6/2013)