



PROVIDER DISPUTE RESOLUTION REQUEST

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

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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.

Mail the completed form to:

**Greater Tri Cities IPA
PO Box 5059
Oceanside, CA 92052**

*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

<i>For Health Plan Use Only</i>
TRACKING NUMBER
PROVIDER ID#



PROVIDER DISPUTE RESOLUTION REQUEST (For use with multiple “LIKE” claims)

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

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED



PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:		PROVIDER ID#:	
a. PROVIDER NAME:		b. CONTRACTED PROVIDER: ____ YES ____ NO	
c. DATE DISPUTE RECEIVED (Date Stamped):		d. DATE OF INITIAL PAYMENT OR ACTION:	
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) ____ YES ____ NO (If NO, should be returned to provider without action)			
f. DISPUTE TYPE: <input type="checkbox"/> CLAIM ISSUE <input type="checkbox"/> OVERPAYMENT REIMBURSEMENT REQUEST <input type="checkbox"/> BILLING ISSUE <input type="checkbox"/> CONTRACT ISSUE <input type="checkbox"/> UM/MEDICAL NECESSITY ISSUE <input type="checkbox"/> OTHER _____ (Please specify type of "other")			
g. DATE DISPUTE ACKNOWLEDGED:		h. TURNAROUND TIME (g – c):	

TYPE OF LETTER SENT: (List the various ICE letters as applicable)

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	k. ACTION TURNAROUND TIME (j – c):	l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):
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IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:		n. TURNAROUND TIME (m – c):	
o. DATE ADDITIONAL INFO RECEIVED:		p. RECEIPT TURNAROUND TIME (o – m):	
q. DATE OF ACTION:	r. ACTION TURNAROUND TIME (q – o):	s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):	

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:
