

# 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: Riverside Family Health Medical Group  
P.O. Box 571450  
Tarzana, CA 91357

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID # / Medicare ID #:</b>
<b>PROVIDER ADDRESS:</b>	

**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:* \_\_\_\_\_

<b>* Patient Name:</b>		<b>Date of Birth:</b>	
<b>* Health Plan and ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)	
<b>Service "From/To" Date:</b> ( * Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>	

<b>DISPUTE TYPE</b>	
<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:**

<b>Contact Name (please print)</b>	<b>Title</b>	(    )
<b>Signature</b>	<b>Date</b>	<b>Phone Number</b>
		(    )
		<b>Fax Number</b>

[    ] **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		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									

Page \_\_\_\_\_ of \_\_\_\_\_

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

# PROVIDER DISPUTE RESOLUTION REQUEST

## Tracking Form

*(For Optional Use by Health Plan/Delegated Provider)*

### 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.

<b>TRACKING NUMBER:</b>	<b>PROVIDER ID#:</b>
<b>a. PROVIDER NAME:</b>	<b>b. CONTRACTED PROVIDER:</b> ____ YES    ____ NO
<b>c. DATE DISPUTE RECEIVED (Date Stamped):</b>	<b>d. DATE OF INITIAL PAYMENT OR ACTION:</b>
<b>e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d)</b> ____ YES    ____ NO <b>(If NO, should be returned to provider without action)</b>	
<b>f. DISPUTE TYPE:</b> <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 _____ <span style="margin-left: 150px;">(Please specify type of "other")</span>	
<b>g. DATE DISPUTE ACKNOWLEDGED:</b>	<b>h. TURNAROUND TIME (g – c):</b>

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

**IF NO ADDITIONAL INFORMATION REQUESTED:**

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

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

<b>COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:</b>
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