PROVIDER DISPUTE RESOLUTION REQUEST

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.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: **Imperial Health Plan of California**
  P.O. Box 60874
  Pasadena, CA 91116

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

PROVIDER TYPE

☐ MD
☐ Mental Health Professional
☐ Mental Health Institutional
☐ Hospital
☐ ASC
☐ SNF
☐ DME
☐ Rehab
☐ Home Health
☐ Ambulance
☐ Other _____ _____ (Specify Other)

CLAIM INFORMATION ☐ Single ☐Multiple "**LIKE"** Claims (complete attached spreadsheet) - *Number ofclaims*:_

*** 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
☐ Disputing 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

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For Health Plan/RBO Use Only

TRACKING NUMBER_____ PROV ID# _____

CONTRACTED_____ NON-CONTRACTED _____

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For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date
	Last	First				
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)

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