

## 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:
 

Network Medical Management  
 Claims Research and Resolution  
 1600 Corporate Center Dr., Suite 101  
 Monterey Park, CA. 91754

<b>*PROVIDER NPI:</b>	<b>PROVIDER TAX ID:</b>
<b>*PROVIDER NAME:</b>	
<b>PROVIDER ADDRESS:</b>	

**PROVIDER TYPE**     MD     Mental Health Professional     Mental Health Institutional     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 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"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

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

[ ] Check here if addition information is attached. *Please do not staple*

*For Health Plan/RBO Use Only*

TRACKING NUMBER \_\_\_\_\_ PROV ID# \_\_\_\_\_

CONTRACTED \_\_\_\_\_ NON-CONTRACTED \_\_\_\_\_

**PROVIDER DISPUTE RESOLUTION REQUEST**  
**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	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

# 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 or NPI#:</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.1. DISPUTE TYPE:</b> <input type="checkbox"/> CLAIM <input type="checkbox"/> APPEAL OF MEDICAL NECESSITY/UM DECISION <input type="checkbox"/> BILLING DETERMINATION <input type="checkbox"/> OVERPAYMENT DISPUTE <input type="checkbox"/> CONTRACT DISPUTE <input type="checkbox"/> OTHER _____ (Please specify type of "other")	
<b>f.2. PROVIDER TYPE:</b> <input type="checkbox"/> PROFESSIONAL <input type="checkbox"/> INSTITUTIONAL <input type="checkbox"/> OTHER	
<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</b> <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER
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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</b> <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER

**COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:**