

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. 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:

L.A. Care Claims Department / Appeals and PDR Unit
P. O. Box 811610, L.A., CA 90081
Fax # (213) 438-5793

*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
(Please do not staple additional information)

<i>For Health Plan Use Only</i> 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)

Page ____ of ____

(6/2013)