CHOC HEALTH ALLIANCE

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:**

CHOC/CPN Provider Appeals – c/o Rady Children's Hospital San Diego
3020 Children's Way, Mail Code 5144
San Diego, CA 92123

***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: ______________________________
(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:
☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ 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 IS ATTACHED**

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)

	* 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
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page ______ of ______

ICE Approved 10/5/07, effective 1/1/08
CHAVersion 04-07-2015 LLG