PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST (Attachment A)

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.
- Mail the completed form to: **Partnership HealthPlan of California**
  Attn: Claims PDR
  P.O. Box 1368
  Suisun City, CA 94585-3172

Note: DO NOT USE THIS FORM FOR UM/MEDICAL NECESSITY/TAR OR PHARMACY APPEALS
FAX UM/TAR APPEALS TO: **(707)863-4118** FAX PHARMACY APPEALS TO: **(707) 863-7330**

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

PROVIDER TYPE: ☐ MD/PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance/Transportation ☐ MH ☐ Other ______________________________
(please specify)

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet)

***Member Name:**		***Date of Birth:**
***CIN/Mem ID Number:**	**Patient Account Number:**	***Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
***Service "From and To" Date:**	***Original Claim Amount Billed:**	**Original Claim Amount Paid:**

***DISPUTE TYPE**

☐ Corrected claim/Additional documentation attached
☐ Underpayment
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Retroactive Authorization now on file
☐ Other:

***DESCRIPTION OF DISPUTE:**

***EXPECTED OUTCOME:**

______________________ ______________________ ______________________
Contact Name (please print) **Title** **Phone Number**

____
Date

For PHC 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								

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