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 # 213-438-5057

*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:

☐ Claim
☐ Appeal of Medical Necessity/Utilization Management Decision
☐ 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 staple additional information)

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#