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 / DSNP 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	☐ Seeking Resolution of a Billing Determination
☐ Appeal of Medical Necessity/Utilization Management	☐ Contract Rate Dispute
☐ Request For Determination of Overpayment	☐ 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#

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)
NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIEN

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)

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7/2023