PROVIDER DISPUTE RESOLUTION REQUEST FORM

- Please ensure completion of all relevant details below. Items marked with an asterisk (*) are required.
- Please be specific and include all information when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Please provide additional information to support the dispute.
- Please note that this process is not intended for claims follow-up or to check status of payment, those requests will be rejected.

MAIL COMPLETED FORM AND ANY SUPPORTING DOCUMENTATION TO:
L.A. Care Provider Dispute Resolution Unit
P.O. Box 811610 Los Angeles, CA 90081
Fax # (213) 438-5057

Provider Questionnaire*	Member Line of Business*
1) Are you a provider disputing a previously processed claim or dispute? If yes, proceed. If no, please redirect your request to the appropriate business unit. a) Underpayment Dispute – Go to section 1 b) Overpayment Dispute – Go to section 2 c) Medical Necessity Dispute – Go to section 3 d) Other – Go to section 4	☐ Medi-Cal ☐ L.A. Care Covered California (LACC(D)) ☐ PASC-SEIU ☐ L.A. Care Medicare (DSNP)

Section 1: Claim Dispute*

a) Have you received payment for the services rendered? ☐ Yes ☐ No
b) Was your payment made by L.A. Care? ☐ Yes ☐ No (if no, continue to question c)
c) Was your payment made by L.A. Care's delegated entity? ☐ Yes ☐ No
If yes, submit your dispute with supporting documentation, 1st level review from delegated entity and EOB/RA from delegated entity.
d) Dispute Type: ☐ Contract Rate ☐ Fee-For-Service ☐ Billing Determination
*Failure to submit supporting documentation may result in a rejection or delay in resolution
e) Is this a corrected claim or first-time submission? Send your hard copy claims to L.A. Care's PO box or electronic claims through L.A. Care's clearinghouses. Refer to https://www.lacare.org/providers/claims for details on claims submissions.

Section 2: Overpayment Dispute*

a) Did you receive an overpayment notice from L.A. Care? ☐ Yes ☐ No
If yes, continue answering the below questions
☐ Special Investigation Unit ☐ Payment Integrity - Clinical ☐ Payment Integrity – Data Mining
b) If you received an overpayment notice from L.A. Care, do you agree with the overpayment? ☐ Yes ☐ No
c) Are you disputing the overpayment notice? ☐ Yes ☐ No
If you are disputing the overpayment, submit the overpayment notice, completed PDR form detailing the reason for dispute and expected outcome, list of claims impacted and supporting documentation.
For multiple "Like" claims dispute, please provide the dispute reason and expected outcome for each claim.
*Failure to submit supporting documentation may result in a rejection or delay in resolution

Section 3: Medical Necessity Dispute*

a) Were the services previously denied due to medical necessity? ☐ Yes ☐ No
If you answered YES, does your dispute include additional supporting documentation (clinical information), denied authorization and/or 1st level review
Note: If this is a second level dispute, please include the first level dispute determination, supporting documentation and detailed reason for dispute.
*Failure to submit supporting documentation may result in a rejection or delay in resolution
b) If you answered NO, are you requesting retrospective review for services that were denied for no authorization?
☐ Yes ☐ No
If you answered YES, please send your request to L.A. Care's Utilization Management for review along with clinical supporting documentation. Refer to https://www.lacare.org/providers/utilization-management/authorizations for details on authorizations.

Section 4: Other*

Please specify:

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Provider Information*	
Provider Type: ☐ Ambulance ☐ Ambulatory Surgery Center ☐ Ancillary ☐ Dialysis ☐ Durable Medical Equipment ☐ Facility ☐ Home Health ☐ Hospice ☐ Hospital – Inpatient ☐ Hospital – Outpatient ☐ Mental Health ☐ Physician ☐ Rehabilitation ☐ Skilled Nursing Facility ☐ Other _____	
*Provider/Group Name:	*Provider Tax ID
*Provider Billing Address	*Provider NPI
*Provider Physical Address	

Member Information*	
*Patient Name	*Date of Birth
*Health Plan ID#:	*Patient Account #:

Is this related to a ☐ Single Claim or ☐ Multiple "LIKE" claims # of claims _____

Claim Information*	
*Service "From/To" Date:	*Claim Amount Billed:
*Original Claim #: (Please use page three of this form when reporting multiple claims)	*Claim Paid Amount:
*Description of Dispute	
*Expected Outcome	

Contact Information*		
*Contact Name	*Title	*Date
*Contact Email	*Contact Phone Number	*Fax Number

☐ Please identify if L.A. Care letter identified above is included

☐ Please identify if 'additional information' is included

PROVIDER DISPUTE RESOLUTION REQUEST FORM

(For use with multiple claims)

ALL FIELDS ON THIS FORM ARE REQUIRED*

Number	Member Last Name	Member First Name	Date of Birth	Member ID Number	Claim ID Number	Date of Service	Billed Amount	Paid Amount	Issue	Expected Outcome
1										
2										
3										
4										
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