

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: **Alameda Hospital**

Alvarado Hospital
P. O. Box 572860
Tarzana, CA 91357

*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 and 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 Decision	☐ Contract Dispute
☐ Request For Reimbursement Of Overpayment	☐ Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:	
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Contact Name (please print)

Title

()
Phone Number

Signature

Date _____

()
Fax Number

☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

T-6

PROVIDER DISPUTE RESOLUTION REQUEST **(For use with multiple “LIKE” claims)**

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Number	* 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	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED