# 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:

  Associated Hispanics
  P. O. Box 571450
  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
☐ 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**

*For Health Plan Use Only*
TRACKING NUMBER
PROVIDER ID#

**T-6**

# PROVIDER DISPUTE RESOLUTION REQUEST
# (For use with multiple "LIKE" claims)

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

| 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 | | | | | | | |
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Reset Form | Save | Print

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**