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.
- Claims must have been paid or denied to be disputed. Provide additional information to support the description of the dispute. **Do not include a copy of the claim that was previously processed.**
- Multiple "LIKE" claims are for the same provider and dispute reason but different members and dates of service.
- Do not use this form for submitting a Corrected Claim.
- Mail the completed form to: **Alameda Alliance for Health, Attn: PDR Unit**
  P.O. Box 2460
  Alameda, CA 94501-4506

***PROVIDER NPI:**	***PROVIDER TAX ID:**
***PROVIDER NAME:**	
***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 sheet) *Number of claims*:_____

***Patient Name:**		***Date of Birth:**
***Health Plan ID Number:**	**Patient Account Number:**	***Original Claim ID Number:** (If multiple LIKE claims, use attached sheet)
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
☐ Disputing 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)**

ICE Approved 10/5/07, effective 1/1/08

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)
NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

	*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
	Last	First						
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)**

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