

ALAMEDA ALLIANCE PROVIDER DISPUTE RESOLUTION REQUEST

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.
- Multiple "LIKE" claims are when the claim is for the same provider, same dispute, and different member.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.

Mail the completed form to: Alameda Alliance for Health, P. O. Box 2460, Alameda, CA 94501-2460

* PROVIDER NPI:	* PROVIDER TAX ID:
* PROVIDER NAME	
PROVIDER ADDRESS:	

PROVIDER TYPE MD Mental Health Professional Mental Health Institutional 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	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> 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)

For Health Plan/RBO Use Only

TRACKING NUMBER _____ PROV ID# _____

CONTRACTED _____ NON-CONTRACTED _____