

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 Status Check Form** not the Provider Dispute Resolution Form.
- Mail the completed form to:

GEMCare	DRMG	CHW EPO
P.O. Box 940	P.O. Box 2538	P.O. Box 752
Bakersfield, CA 93302	Bakersfield, CA 93303	Bakersfield, CA 93302

*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 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"/> Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	()
Signature	Date	Phone Number
		()
		Fax Number

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
 (Please do not staple additional information)

For Health Plan Use Only

TRACKING NUMBER

PROVIDER ID#

**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									

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CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple additional information)