PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- x Please complete this form. Fields with an asterisk (*) are required.
- x Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- x Provide additional information to support the description of the dispute.
- x For routine follow-up regarding claims status, please contact the CalOptima Claims Provider Line: **714-246-8885**
- x Mail the completed form to: CalOptima Claims Provider Dispute
  P.O. Box 57015
  Irvine, CA 92619

PRODUCT TYPE: ☐ MEDI-CAL ☐ MEDICARE ☐ COMMERCIAL	
*** PROVIDER NPI:**	*** PROVIDER TAX ID # / Medicare ID #:**
*** PROVIDER NAME:**	**CONTRACTED:** ☐ YES ☐ NO
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

- ☐ 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.)**

For Health Plan Use Only

TRACKING #_____ PROV ID#_____
CONTRACTED_____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

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 (Please do not staple)**