# 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. Include a copy of a claim that is being disputed.
- For routine follow-up, please use the **Claims Follow-Up/Inquiry Form** instead of this form.
- Email the completed form to: claims@cchca.com

| *PROVIDER NAME: | *PROVIDER TAX ID # / Medicare ID #: |
|---|---|
| **PROVIDER ADDRESS:** | |

**PROVIDER TYPE** ❑ MD ❑ Lab / X-ray ❑ Mental Health ❑ Hospital ❑ SNF ❑ DME ❑ Rehab ❑ Home Health ❑ Ambulance ❑ Other (please specify type of "other")

*** CLAIM INFORMATION** ❑ Single ❑ Multiple 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 C aim, 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**
**(Please do not staple additional information)**

# PROVIDER DISPUTE RESOLUTION REQUEST
# (For use with multiple "LIKE/SIMILAR" 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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Page_______of ______

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