

ALTAIS | BROWN & TOLAND PROVIDER DISPUTE RESOLUTION REQUEST FORM

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the form below. 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 for the same provider and dispute but different members and dates of service.
- **For routine follow-up and standard questions, you may call Brown & Toland Customer Service at (415) 972-6002.**
- Mail the completed form to: Altas | Brown & Toland Provider Dispute Unit
P.O. Box 72710
Oakland, CA 94612-8910

*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

- | | |
|--|--|
| ☐ Claim | ☐ Seeking Resolution Of A Billing Determination |
| ☐ Appeal of Medical Necessity / Utilization Management Decision | ☐ Contract Dispute |
| ☐ Disputing Request For Reimbursement Of Overpayment | ☐ Other: |

* DESCRIPTION OF DISPUTE:

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

HICE Approved 10/5/07, 8/1/23 eff. 1/1/08

EXPECTED OUTCOME:

Contact Name (please print)

Title

Phone Number

()

Signature

Date

Fax Number

For Health Plan/RBO Use Only

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

For use with multiple “LIKE” claims (claims disputed for the same reason)

For use with multiple “LIKE” claims (claims disputed for the same reason)

	* 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								

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:		PROVIDER ID or NPI#:	
a. PROVIDER NAME:		b. CONTRACTED PROVIDER: ____ YES ____ NO	
c. DATE DISPUTE RECEIVED (Date Stamped):		d. DATE OF INITIAL PAYMENT OR ACTION:	
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) ____ YES ____ NO (If NO, should be returned to provider without action)			
f.1. DISPUTE TYPE: ☐ CLAIM ☐ APPEAL OF MEDICAL NECESSITY/UM DECISION ☐ BILLING DETERMINATION ☐ OVERPAYMENT DISPUTE ☐ CONTRACT DISPUTE ☐ Other _____			
f.2. PROVIDER TYPE: ☐ PROFESSIONAL ☐ INSTITUTIONAL ☐ OTHER			
g. DATE DISPUTE ACKNOWLEDGED:		h. TURNAROUND TIME (g – c):	

TYPE OF LETTER SENT: (List the various ICE letters as applicable)

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	k. ACTION TURNAROUND TIME (j – o):	l. TYPE OF ACTION ☐ UPHELD ☐ OVERTURNED ☐ OTHER
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IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:		n. TURNAROUND TIME (m – c):							
o. DATE ADDITIONAL INFO RECEIVED:		p. RECEIPT TURNAROUND TIME (o – m):							
q. DATE OF ACTION:	r. ACTION TURNAROUND TIME (q – o):	s. TYPE OF ACTION <table border="1"><tr><td>☐</td><td>UPHELD</td></tr><tr><td>☐</td><td>OVERTURNED</td></tr><tr><td>☐</td><td>OTHER</td></tr></table>		☐	UPHELD	☐	OVERTURNED	☐	OTHER
☐	UPHELD								
☐	OVERTURNED								
☐	OTHER								

ACTION (If decided in whole or part on behalf of provider, apply appropriate interest to payment or partial COMPLETE DESCRIPTION OF DETERMINATION RATIONALE: payment and make payment within 5 days of issuing determination):