altais care network
Family Care Specialists

# ALTAIS | FAMILY CARE SPECIALISTS 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 please use the claims follow up form instead of the dispute resolution form
- Mail the completed form to: Altais | Family Care Specialists
  P.O. Box 72670
  Oakland, CA 94612

| ***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
☐ 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:**

[ ] **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 _____

# PROVIDER DISPUTE RESOLUTION REQUEST
## 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 |
|---|---|---|

**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**<br>☐ UPHELD<br>☐ OVERTURNED<br>☐ 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):** |
| |