altais | Care Network | Family Care Specialists IPA

PROVIDER DISPUTE RESOLUTION REQUEST

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.
- 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 Provider Dispute Resolution Form.
- Mail the completed form to: 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:**

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 _____

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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								

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

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 _____ (Please specify type of "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 – c):**	**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** ☐ UPHELD ☐ OVERTURNED ☐ OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE: