HUMBOLDT IPA PROVIDER DISPUTE RESOLUTION REQUEST FORM

Submission of this form constitutes agreement not to bill the patient during the dispute resolution process.

INSTRUCTIONS

- For routine claim status, please visit our website, portal.humboldtipa.com.
- For other claim review requests, please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE.
- Provide additional information to support the description of the dispute. Please only provide information related to the procedure billed and no more than 1 year prior to the date of service on the claim.
 DISPUTES RECEIVED WITH NO ADDITIONAL INFORMATION WILL NOT BE CONSIDERED FOR REVIEW.
- Send the completed form by mail to The Humboldt IPA, 2662 Harris Street, Eureka, CA 95503 or by fax to (707) 442-2047.
- PDR status can be obtained on our website, portal.humboldtipa.com.

*PROVIDER NAME:

*PROVIDER TAX ID #:_____

* Patient Name:				Date of Birth:		
* Health Plan Name	Patient Account Number:		*Original Claim ID Number:			
* Health Plan ID Number:						
*Service "From/To" Date		*Original Claim	I Claim Amount Billed:		*Original Claim Amount Paid:	
DISPUTE TYPE						
			Seeking Resolution Of A Billing Determination			
Appeal of Medical Necessity / Utilization Management Decision			Contract Dispute			
Request For Reimbursement Of Overpayment			Other:			
*DESCRIPTION OF DISPUTE:						

*Contact Name (please print)

Title

*Phone Number