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 follow-up, please use the Claims Status Request Form instead of the Provider Dispute Resolution Form.
- For other claim review requests, please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and REQUESTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Send the completed form by mail to The IPA, 2662 Harris Street, Eureka, CA 95503 or by fax to (707) 442-2047.

***PROVIDER NAME:**_____ ***PROVIDER TAX ID #:**_____

PROVIDER ADDRESS:_____

PROVIDER TYPE: ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance ☐ Other_____
(please specify type of "other")

*** CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE"** Claims *Number of claims*:___

*** Patient Name:**		**Date of Birth:**
*** Health Plan Name** *** 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
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

***DESCRIPTION OF DISPUTE:**

REQUESTED OUTCOME:

[ ] **Check here if additional information is attached.**

Contact Name (please print)	**Title**	**( ) Phone Number**
Signature	**Date**	**( ) Fax Number**

Rev. 01/2015