

# 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, 2315 Dean Street, Eureka, CA 95501 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 Amount Billed:	*Original Claim Amount Paid:

<b>DISPUTE TYPE</b>	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

<b>*DESCRIPTION OF DISPUTE:</b>          
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_____	_____	( ) _____
<b>*Contact Name (please print)</b>	<b>Title</b>	<b>*Phone Number</b>
		( ) _____
		<b>*Fax Number</b>