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.
- For routine follow-up regarding claims status, please contact the CalOptima Claims Provider Line: 714-246-8885
- Mail the completed form to: CalOptima Claims Provider Dispute
  P.O. Box 11037
  Orange, CA 92856

PRODUCT TYPE: ☐ MEDI-CAL ☐ MEDICARE ☐ COMMERCIAL

***PROVIDER NPI:**	***PROVIDER TAX ID # / Medicare ID #:**
***PROVIDER NAME:**	**CONTRACTED:** ☑ YES ☐ NO
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**

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple)

For Health Plan Use Only

TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

Number	* 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	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**