PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

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.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form. Mail the completed form to: **Prospect Medical Group** Provider Disputes Department
  600 City Parkway West, Suite 1000, Orange CA, 92868

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare 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 (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
☐ 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 additional information)

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

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