

# Greater Orange County Medical Group

1600 Corporate Center Dr., Suite 101, Monterey Park, CA 91754 Phone (626) 282-0288 • Fax (626) 943-6369

## 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. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to:  
Network Medical Management  
Claims Research and Resolution  
1600 Corporate Center Dr., Suite 101  
Monterey Park, CA. 91754

\*PROVIDER NPI:

PROVIDER TAX ID:

\*PROVIDER NAME:

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  Seeking Resolution Of A Billing Determination  
 Appeal of Medical Necessity / Utilization Management Decision  Contract Dispute  
 Disputing Request For Reimbursement Of Overpayment  Other:

\* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print)

Title

Phone Number

Signature

Date

Fax Number

[ ] Check here if addition information is attached. *Please do not staple*

*For Health Plan/RBO Use Only*

TRACKING NUMBER \_\_\_\_\_ PROV ID# \_\_\_\_\_

CONTRACTED \_\_\_\_\_ NON-CONTRACTED \_\_\_\_\_

**PROVIDER DISPUTE RESOLUTION REQUEST**  
**For use with multiple "LIKE" claims (claims disputed for the same reason)**

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

# PROVIDER DISPUTE RESOLUTION REQUEST

## Tracking Form

*(For Optional Use by Health Plan/Delegated Provider)*

### INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

<b>TRACKING NUMBER:</b>		<b>PROVIDER ID or NPI#:</b>	
<b>a. PROVIDER NAME:</b>		<b>b. CONTRACTED PROVIDER:</b> ____ YES    ____ NO	
<b>c. DATE DISPUTE RECEIVED (Date Stamped):</b>		<b>d. DATE OF INITIAL PAYMENT OR ACTION:</b>	
<b>e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d)</b> ____ YES    ____ NO <b>(If NO, should be returned to provider without action)</b>			
<b>f.1. DISPUTE TYPE:</b> <input type="checkbox"/> CLAIM <input type="checkbox"/> APPEAL OF MEDICAL NECESSITY/UM DECISION <input type="checkbox"/> BILLING DETERMINATION			
<input type="checkbox"/> OVERPAYMENT DISPUTE <input type="checkbox"/> CONTRACT DISPUTE <input type="checkbox"/> OTHER _____ <span style="display: block; text-align: right; font-size: small;">(Please specify type of "other")</span>			
<b>f.2. PROVIDER TYPE:</b> <input type="checkbox"/> PROFESSIONAL <input type="checkbox"/> INSTITUTIONAL <input type="checkbox"/> OTHER			
<b>g. DATE DISPUTE ACKNOWLEDGED:</b>		<b>h. TURNAROUND TIME (g – c):</b>	

**TYPE OF LETTER SENT:**        (List the various ICE letters as applicable)

**IF NO ADDITIONAL INFORMATION REQUESTED:**

<b>j. DATE OF ACTION:</b>	<b>k. ACTION TURNAROUND TIME (j – c):</b>	<b>l. TYPE OF ACTION</b> <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER
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**IF ADDITIONAL INFORMATION REQUESTED:**

<b>m. DATE ADDITIONAL INFO REQUESTED:</b>		<b>n. TURNAROUND TIME (m – c):</b>	
<b>o. DATE ADDITIONAL INFO RECEIVED:</b>		<b>p. RECEIPT TURNAROUND TIME (o – m):</b>	
<b>q. DATE OF ACTION:</b>	<b>r. ACTION TURNAROUND TIME (q – o):</b>	<b>s. TYPE OF ACTION</b> <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER	

<b>COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:</b>
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