Hospital Directed Payment Dispute Form

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| INSTRUCTIONS: |
|  | Please complete the below form. Fields with an asterisk (\*) are required. Provide additional information to support the description of the disputeFor routine follow-up status, please call the IEHP Provider Team at (909) 890-2054 or (866) 223-4347 Monday- Friday 8:00 am to 5:00 pm PSTPlease email completed form to PHDP-EPPinquiry@iehp.org. IEHP will acknowledge dispute within 48 hours with a resolution within 30 business days from dispute receipt date.  |  |
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| \*Hospital Name: | \*Hospital NPI #: | \*Hospital Tax ID # |
| \*Dispute Type: [ ] Non-Payment [ ] Underpayment | \*Program Phase: | \*Program [ ] EPP [ ] PDHP |

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| \*Description of Dispute: |
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| *In addition to description please also provide a spreadsheet with the below data elements for all encounters in question.* |
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| \*Claim ID | \*PCN  | \*Service Dates  | \*Claim type  Inst/Prof | \*Patient NameFirst,Last  | DOB  | \*IEHP Subscriber ID | \*IPA NameIf IPA Encounter | \*IPA Claim Number  |
| Start  | End  |  |  |
|  |  |  |  |  |  |  |  |  |  |
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 Contact Name (please print) Title Phone Number Signature Date Fax Number |