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 dispute  For 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 PST  Please email completed form to [PHDP-EPPinquiry@iehp.org](mailto:PHDP-EPPinquiry@iehp.org). IEHP will acknowledge dispute within 48 hours with a resolution within 30 business days from dispute receipt date. |  |
| |  |  |  | | --- | --- | --- | | \*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.* | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | \*Claim ID | \*PCN | \*Service Dates | | \*Claim type  Inst/Prof | \*Patient Name  First,Last | DOB | \*IEHP Subscriber ID | \*IPA Name  If IPA Encounter | \*IPA Claim Number | | Start | End |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |   Contact Name (please print) Title Phone Number  Signature Date Fax Number | |