# 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.
- 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 or visit our Secure Provider Portal available for contracted providers at www.iehp.org.
- Place this completed form at the top of any attachments related to your dispute and mail to:

  IEHP Claims Appeal Resolution Unit
  P.O. Box 4319
  Rancho Cucamonga, CA 91729-4319

| *PROVIDER NAME: | *PROVIDER TAX ID # / Medicare ID #: |
|---|---|
| **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/RBO Use Only*
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

# PROVIDER DISPUTE RESOLUTION REQUEST
## (*For use with multiple "LIKE" claims*)

| 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 |
|---|---|---|---|---|---|---|---|---|
| | Last | First | | | | | | |
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[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

**Form Updated: 09/2013**