Scripps | Health Plan Services

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: Scripps Health Plan Services
  P.O. Box 2079
  La Jolla, CA 92038
  Fax: 858-260-5845

***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:**

***Member 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)
ICE Approved 10/05/07, effective 1/1/08

Last update: v2 021717

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

Scripps | Health Plan Services

Provider Dispute Resolution Request

For use with multiple "LIKE" claims (claims disputed for the same reason).
Please complete the below form. Fields with an asterisk (*) are required.

	*Member Name		*Date of Birth	*Member 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								

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