



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:		
<input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Disputing Request For Reimbursement of Overpayment	<input type="checkbox"/> Seeking Resolution of a Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> 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

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

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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