

FOUNDATION PROVIDER DISPUTE RESOLUTION REQUEST FORM

Submission of this form constitutes agreement not to bill the patient during the dispute resolution process.

INSTRUCTIONS

- For routine follow-up, please use the Claims Status Request Form instead of the Provider Dispute Resolution Form.
- For other claim review requests, please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and REQUESTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Send the completed form by mail to The Foundation, P. O. Box 1395, Eureka, CA 95502 or by fax to (707) 443-2527.

***PROVIDER NAME:** _____ ***PROVIDER TAX ID #:** _____

PROVIDER ADDRESS: _____

PROVIDER TYPE: MD Mental Health 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 Name	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)	
* Health Plan ID Number:			
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"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

***DESCRIPTION OF DISPUTE:**

REQUESTED OUTCOME:

[] Check here if additional information is attached.

Contact Name (please print)	Title	()
Signature	Date	Phone Number
		()
		Fax Number

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

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

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						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page _____ of _____

