# IEHP MEDI-CAL PROVIDER DISPUTE RESOLUTION REQUEST

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| --- |
| **INSTRUCTIONS*** Please complete the below form. Fields with an asterisk (\*) are required. Incomplete form will not be processed. 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.**
* **Corrected claims are not considered to be disputes.**
* For claim/appeal status, please call the IEHP Provider Call Center 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.](http://www.iehp.org/)
* Place this completed form at the top of any attachments related to your dispute and mail to:

IEHP Provider Claims Resolution & Recovery Unit P.O. Box 4319Rancho Cucamonga, CA 91729-4319 |
| **\*PROVIDER NAME:** | **\*PROVIDER TAX ID # / Medicare ID #:** |
| **PROVIDER ADDRESS:** |

## 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 Seeking Resolution Of A Billing DeterminationAppeal of Medical Necessity / Utilization Management Decision Contract Dispute Disputing Request For Reimbursement Of Overpayment Other: |

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

 **( )**

## Contact Name (please print) Title Phone Number

 **( )**

## Signature Date Fax Number

] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

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*For Health Plan/RBO Use Only*

TRACKING NUMBER PROV ID# CONTRACTED NON-CONTRACTED

**(Please do not staple)**

# 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** |
| 1 |  |  |  |  |  |  |  |  |
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[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

**(Please do not staple) Form Updated: 09/2013**