

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:

Sharp Health Plan
Attn: Provider Dispute Resolution
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax Number: (858) 636-2276

PRODUCT TYPE:		COMMERCIAL		MEDI-CAL		MEDICARE
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*PROVIDER NPI:		PROVIDER TAX ID:	
*PROVIDER NAME:			
PROVIDER ADDRESS:			

PROVIDER TYPE:					
	MD		ASC		Rehab
	Mental Health Professional		SNF		Home Health
	Mental Health Institutional		DME		Ambulance
	Hospital		Other, specify		

CLAIM INFORMATION:		Single		Multiple	Number of Claims	
"LIKE" Claims (complete attached spreadsheet)						

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)	
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* 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:

COMMERCIAL AND MEDI-CAL DISPUTE TYPE:			
	Claim		Downcoding / Payment
	Appeal of Medical Necessity/Utilization Management Decision		Seeking Resolution of a Billing Determination
	Contract Dispute		Other, Specify
	Disputing Request For Reimbursement of Overpayment		

MEDICARE DISPUTE TYPE:	
	Medicare Fee Schedule Payment Dispute
* DESCRIPTION OF DISPUTE:	
EXPECTED OUTCOME:	

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

For Health Plan / RBO Use Only

TRACKING NUMBER		CONTRACTED	
PROV ID #		NON-CONTRACTED	

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple “LIKE” claims (claims disputed for the same reason)

	<i>* Patient Name</i>		<i>Date of Birth</i>	<i>* Health Plan ID Number</i>	<i>Original Claim ID Number</i>	<i>* Service From/To Date</i>	<i>Original Claim Amount Billed</i>	<i>Original Claim Amount Paid</i>
	<i>Last</i>	<i>First</i>						
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PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, timeframes, and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:			
PROVIDER ID OR NPI #:			
a. PROVIDER NAME			
b. CONTRACTED PROVIDER		YES	NO
c. DATE DISPUTE RECEIVED (Date Stamped):			
d. DATE OF INITIAL PAYMENT OR ACTION:			
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d)		YES	NO
(If No, should be returned to provider without action)			

f.1 COMMERCIAL OR MEDI-CAL DISPUTE TYPE:			
	Claim		Downcoding / Payment
	Appeal of Medical Necessity/Utilization Management Decision		Seeking Resolution of a Billing Determination
	Contract Dispute		Other, Specify
	Disputing Request For Reimbursement of Overpayment		
f.2 MEDICARE DISPUTE TYPE:			
	Medicare Fee Schedule Payment Dispute		
f.3 PROVIDER TYPE:		PROFESSIONAL	INSTITUTIONAL
g. DATE DISPUTE ACKNOWLEDGED:		h. TURNAROUND TIME (g – c)	
		OTHER	

i. TYPE OF LETTER SENT: (List the various HICE letters as applicable)	
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IF NO ADDITIONAL INFORMATION REQUESTED:	
j. DATE OF ACTION:	
k. ACTION TURNAROUND TIME (j – c):	
l. TYPE OF ACTION:	UPHELD
	OVERTURNED
	OTHER

IF ADDITIONAL INFORMATION REQUESTED:	
m. DATE ADDITIONAL INFO REQUESTED:	
n. TURNAROUND TIME (m – c):	
o. DATE ADDITIONAL INFO REQUESTED:	
p. RECEIPT TURNAROUND TIME (o – m):	
q. DATE OF ACTION:	
r. ACTION TURNAROUND TIME (q – o):	
s. TYPE OF ACTION:	UPHELD
	OVERTURNED
	OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:	
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ACTION: (If decided in whole or part on behalf of provider, apply appropriate interest to payment or partial payment and make payment within 5 days of issuing determination)	
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