

# 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: **Rady Children's Health Network**  
3020 Children's Way, MC 5077  
San Diego, CA 92123

<b>*PROVIDER NPI:</b>	<b>PROVIDER TAX ID:</b>
<b>*PROVIDER NAME:</b>	
<b>PROVIDER ADDRESS:</b>	

**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:* \_\_\_\_\_

<b>* Patient Name:</b>		<b>Date of Birth:</b>	
<b>* Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)	
<b>Service "From/To" Date:</b> ( * Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>	

<b>DISPUTE TYPE</b>	
<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"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

<b>Contact Name (please print)</b>	<b>Title</b>	<b>Phone Number</b>
<b>Signature</b>	<b>Date</b>	<b>(    ) Fax Number</b>

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED  
(Please do not staple)  
HICE Approved 10/5/07, reviewed 8/1/23

*For Health Plan/RBO Use Only*

TRACKING NUMBER \_\_\_\_\_ PROV ID# \_\_\_\_\_

CONTRACTED \_\_\_\_\_ NON-CONTRACTED \_\_\_\_\_

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

	* 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								

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