Health Net®
COMMUNITY SOLUTIONS

Health Net®

COMMERCIAL & MEDI-CAL
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. For provider dispute inquiries or filing information, contact us at the appropriate telephone numbers below.

Mail the completed form to the following addresses. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800- 641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 419086 Rancho Cordova, CA 95741-9086
Medi-Cal Provider Services Center 1-800-675-6110

***PROVIDER NAME:**	***PROVIDER TAX ID #:**
PROVIDER ADDRESS:	**Contracted : Y/N (circle one)**

PROVIDER TYPE ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab ☐ Home health ☐ Ambulance ☐ Other professional (please specify type of "other")_____

*** CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE"** claims (complete attached spreadsheet) Number of claims:___

*** Patient name:**		**Date of birth:**
*** Social Security number :**	***Subscriber ID/CIN number:**	*** Original claim ID number:** (If multiple claims, use attached spreadsheet)
***Service from/to date:**	**Original claim amount billed:**	**Original claim amount paid:**

Dispute Type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute ☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

*** DESCRIPTION OF DISPUTE: Indicate reason for dispute, provider's position and basis therefore:** (Additional paper can be attached if necessary)

*** EXPECTED OUTCOME: (Please provide by claim if multiple.)**

Contact name (please print)	**Title**	**( ) Area code & phone number**
Signature and date	**Email address**	**( ) Area code & fax number**

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

For Health Plan Use Only
Case # _____
Provider #_____

COMMERCIAL & MEDI-CAL PROVIDER DISPUTE RESOLUTION REQUEST, *continued*

INSTRUCTIONS: (For use with multiple like claims only)

- 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.

Mail the completed form to the following addresses. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 419086 Rancho Cordova, CA 95741-9086
Medi-Cal Provider Services Center 1-800-675-6110

Number	*Patient name		Date of birth	*Subscriber ID no./ CIN number	*Original claim ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

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

For Health Plan Use Only
Case # _____
Provider #_____