

Provider Dispute Resolution Request

Commercial and Medi-Cal

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- 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 routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. 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 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

*Provider name:		*Provider tax ID #:	
*Provider address			Contracted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Provider type: <input type="checkbox"/> Physician <input type="checkbox"/> Mental health <input type="checkbox"/> Hospital <input type="checkbox"/> ASC/outpatient services <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other professional (please specify type of other) _____			
*Claim information: <input type="checkbox"/> Single <input type="checkbox"/> Multiple “LIKE” claims (complete attached spreadsheet) Number of claims _____			
*Patient name:			Date of birth:
*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)	
*Service from/to date:	Original claim amount billed:	Original claim amount paid:	
Dispute type: <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of medical necessity/utilization management decision <input type="checkbox"/> Contract dispute <input type="checkbox"/> Seeking resolution of a billing determination <input type="checkbox"/> Disputing a request for reimbursement of overpayment <input type="checkbox"/> Other			
*Description of dispute: Indicate reason for dispute, provider’s position and reasoning: (Additional paper can be attached if necessary)			
*Expected outcome: (Please provide by claim if multiple.)			

_____ () _____
 Contact name (please print) Title Area code and phone number

_____ () _____
 Signature and date Email address Area code and fax number

Check here if additional information is attached:
(Please do not staple information.)

For Health Plan Use Only Case# _____ Provider# _____

Commercial and Medi-Cal Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

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Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission 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:
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<p>For Health Plan Use Only Case# _____ Provider# _____</p>
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