

## INDIVIDUAL FAMILY PLAN (IFP) PROVIDER DISPUTE RESOLUTION REQUEST

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<ul> <li>INSTRUCTIONS</li> <li>Please mail the completed form Fields with an asterisk (*) are re</li> <li>Be specific when completing the DISPUTE and EXPECTED OUT</li> <li>Provide additional information to of the dispute. Do not include a previously processed.</li> <li>IFP Provider Disputes and Appeals PO Box 9040, Farmington, MO 6364</li> </ul>	to the address below. quired. DESCRIPTION OF FCOME. Support the description copy of a claim that was	INSTRUCTIONS Please mark the member's line of business: HMO/POS PPO PureCare HSP PureCare One EPO CommunityCare HMO EnhancedCare PPO PPO Individual and Family			
*PROVIDER NAME:	*PROVI	DER TAX ID #:			
PROVIDER ADDRESS:	TROVI	Contracted : Y/N (circle one)			
TROVIDER ADDRESS.			Contrac		
Rehab      Home health      Ambular     * CLAIM INFORMATION      Single		(please specify type plete attached spre	of other)		
* Patient name:		Date			
* Social Security number :	Social Security number : *Subscriber ID/CIN number: * Origuse at				
*Service from/to date:	Origin	al claim amount billed: Original claim amount paid			
Dispute Type:         Claim         App           Seeking resolution of a billing determination	eal of medical necessity/utiliza	tion management dest for reimburseme		Contract dispute ayment D Other	
* DESCRIPTION OF DISPUTE: Indicate necessary) * EXPECTED OUTCOME: (Please prov		osition and basis the	erefore: (Add	ditional paper can be attached if	
			(	)	
Contact name (places print)			<u>`</u>	·	
Contact name (please print)	Title		Area	code & phone number	
Signature and date	Email address		( Area (	) code & fax number	
[ ] CHECK HERE IF ADDITIONAL INFOR	MATION IS ATTACHED:		For	Health Plan Use Only	
(Please do not staple information.) FRM016048EW00 (12/17)	Ра	ge of		e #	
Health Net of California, Inc., Health Net Community Solutions, Inc. and Centene Corporation. Health Net is a registered service mark o		subsidiaries of Health Net, Inc	Prov	/ider #	

## IFP PROVIDER DISPUTE RESOLUTION REQUEST

## 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.
- For provider dispute inquiries or filing information, contact the Health Net Provider Services at 1-800-641-7761. Mail the completed form to the following address. IFP Provider Disputes and Appeals Unit PO Box 9040 Farmington, MO 63640-9040

	*Patient name				Origin *Service clair	Original claim	nal m Original		
Number	Last	First	Date of birth	*Subscriber ID number	*Original claim ID number	from/to date	amount billed	claim amount paid	*Expected outcome
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

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

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<u>For Health Plan Use Only</u>
Case #
Provider #