Health Net

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 routine follow-up, please use the Provider Inquiry Request form instead of this form.

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

Health Net Provider Appeals Unit
PO Box 10406 Van Nuys, Ca 91410-0406
(800) 641-7761 or go to our website: www.healthnet.com

Health Net Medi-Cal Provider Appeals Unit
PO Box 419086 Rancho Cordova, Ca 95741-9086
Medi-Cal Provider Services (800) 675-6110

For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

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

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)

HN/PDR Form
05/01/13

For Health Plan Use Only
Case # _____
Provider #_____

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS: (For use with multiple "Like" claims only)

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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									

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Case # _____
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