# PROVIDER DISPUTE RESOLUTION REQUEST

***NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.***

**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.
- In order to ensure the integrity of the Provider Dispute Resolution (PDR) process, we will re-categorize issues sent to us on a PDR form which are not true provider disputes (e.g., claims check tracers or a provider's submission of medical records after payment was denied due to a lack of documentation).
- For routine follow-up, use CHCN's Web Portal to view claims status: https://connect.chcnetwork.org/
- Mail the completed form to: CHCN Claims Department
  101 Callan Avenue, Suite 300
  San Leandro, CA 94577

| ***PROVIDER NAME:** | ***PROVIDER TAX ID # / Medicare ID #:** |
|---|---|
| **PROVIDER ADDRESS:** | |

**PROVIDER TYPE** ☐ MD ☐ Other ______________________________
(please specify type of "other")

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

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

**DISPUTE TYPE**

☐ Claim

☐ Disputing Request For Reimbursement Of Overpayment

☐ Seeking Resolution Of A Billing Determination

☐ Contract Dispute

☐ Other:

*** DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

| **Contact Name (please print)** | **Title** | ( ) **Phone Number** |
|---|---|---|
| **Signature** | **Date** | ( ) **Fax Number** |

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