Provider Claim Dispute Resolution Mechanism
(Provider Claims Appeal Process)

A provider claim dispute is a written notice to CHCN challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination, or disputing a request for reimbursement of an overpayment of a claim.

If a provider wants to dispute a claim payment or denial (for reasons not related to provider's claim submission error or omission) the provider can submit a written dispute to the following address:

Community Health Center Network
Attn: Provider Claims Dispute Department
101 Callan Avenue, Suite 300
San Leandro, CA 94577
510-297-0210

Note: Claims that are denied due to provider's claim submission error or omission (e.g. missing/incorrect CPT, ICD-10-CM or place of service codes) or any changes in the claim form made from original submission do not qualify for the Provider Claim Dispute Resolution Mechanism. Claims resubmission with medical records for review due to bundling edits, included services, request for medical records/treatment notes, anesthesia time spent or EOB submissions should be sent directly to claims dept. not through provider disputes. These should be resubmitted within the time period for claim submission as "Corrected Claim" with a brief explanation either noted on the claim or as an attachment.

1. The provider must submit a Notice of Provider Claim Dispute (NOPD) in writing along with any relevant and supporting documentation within 365 days of CHCN's last action or, in the case of inaction, 365 days after the Time for Contesting or Denying Claims has expired.

2. The Provider Claim Dispute must include:
    a. Provider's Name
    b. Provider's ID Number
    c. Provider's Contact Information (Name, Address, Phone Number)
    d. Patient's Name
    e. Patient's DOB
    f. Claim Number (from CHCN remittance advice)
    g. Paper Claim: Copy of the original claim being disputed
    h. Clear identification of the disputed item.
    i. Clear explanation of the basis that provider believes the payment amount, denial, adjustment, or request for reimbursement is incorrect.
    j. Other pertinent documentation to support appeal

3. CHCN will acknowledge the receipt of the written claim dispute within fifteen (15) working days of receipt of the dispute.

4. If CHCN receives an incomplete provider claim dispute, CHCN will return it to the provider with a clear identification of the missing information.

5. The provider has thirty (30) working days from the receipt of the returned NOPD to resubmit an Amended Claim Dispute with the requested information.

6. CHCN will issue a written determination, including a statement of the pertinent facts and reasons, to the provider within forty-five (45) working days after receipt of the provider claim dispute or the amended provider claim dispute.

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES ACKNOWLEDGEMENT CHCN MEDI-CAL MEMBERS ELIGIBLE ON DATE OF SERVICE CANNOT BE BILLED FOR COVERED BENEFITS AT ANY TIME.

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, request for time spent, or request for treatment notes).
- For routine follow-up, use CHCN's Web Portal to view claims status: https://portal.chcnetwork.org/Login
- Mail the completed form to: CHCN PDR 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 ☐ Contract Dispute

☐ Disputing Request For Reimbursement Of Overpayment

☐ Seeking Resolution Of A Billing Determination ☐ Other:

*** DESCRIPTION OF DISPUTE:**

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

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

***Provider Name:**	***Provider NPI#:**

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Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/ To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
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