Dignity Health Management Services

Claims Provider Dispute Resolution Request

Note: Submission of this form constitutes agreement not to bill the patient

Instructions

For routine follow-up, please use the CLAIMS STATUS CHECK form, not the Provider Dispute Resolution form.

- Please complete the form below. 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.

MAIL OR FAX THE COMPLETED FORM TO:

Dignity Health Management Services
PO Box 752
Bakersfield, CA 93302

PHONE: 661.716.7100
FAX: 661.716.9160

Provider Information

LAST NAME*	FIRST NAME*	PROVIDER TYPE
PROVIDER TAX ID NUMBER / MEDICARE ID NUMBER*		☐ MD ☐ Mental Health ☐ ASC ☐ Hospital ☐ SNF ☐ Home Health ☐ DME ☐ Ambulance ☐ Rehab ☐ Other_____ SPECIFY TYPE OF "OTHER"
ADDRESS		
CITY	STATE / ZIP	

Claim Information*

☐ Single ☐ Multiple "Like" Claims (complete attached spreadsheet)	NUMBER OF CLAIMS

Patient Information *(IF MULTIPLE CLAIMS, USE ATTACHED SPREADSHEET)*

LAST NAME*	FIRST NAME*	DATE OF BIRTH
HEALTH PLAN ID NUMBER*	PATIENT ACCOUNT NUMBER	ORIGINAL CLAIM ID NUMBER
SERVICE "FROM / TO" DATE:* *(REQUIRED FOR CLAIMS, BILLING AND REIMBURSEMENT OF OVERPAYMENT)*	ORIGINAL CLAIM AMOUNT BILLED	ORIGINAL CLAIM AMOUNT PAID

Dispute Information

DISPUTE TYPE	DESCRIPTION OF DISPUTE
☐ Claim ☐ Contract Dispute ☐ Claim Appeal of Medical Necessity/Utilization Management Decision ☐ Request For Reimbursement of Overpayment ☐ Seeking Resolution of a Billing Determination	EXPECTED OUTCOME

Contact Information

CONTACT NAME	TITLE	PHONE NUMBER
SIGNATURE	DATE	FAX NUMBER

☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(PLEASE **DO NOT STAPLE** ADDITIONAL INFORMATION)

For Health Plan Use Only

TRACKING NUMBER	PROVIDER ID NUMBER