# IEHP DUALCHOICE (HMO D-SNP) PROVIDER DISPUTE RESOLUTION REQUEST

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| **INSTRUCTIONS*** Please complete the below form. Fields with an asterisk (\*) are required. Incomplete form will not be processed. 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. Corrected claims are not considered to be disputes.**
* For Medicare non-contracted providers, please complete and include in your appeal a fully executed Waiver of Liability (WOL) Statement. If you complete a WOL Statement, you waive the right to collect payment from the member, with the exception of any applicable cost sharing, regardless of the determination made on the appeal. To appeal, mail your request and completed WOL Statement within 60 calendar days after the date of the Notice of Denial of Payment.
* For claim/appeal status, please call the IEHP Provider Call Center at (909) 890-2054 or (866) 223-4347 Monday- Friday 8:00 am to 5:00 pm PST or visit our Secure Provider Portal available for contracted providers at [www.iehp.org.](http://www.iehp.org/)
* Place this completed form at the top of any attachments related to your dispute and mail to:

IEHP Provider Claims Resolution & Recovery Unit P.O. Box 40Rancho Cucamonga, CA 91729-4319 |
| **\*PROVIDER NAME:** | **\*PROVIDER TAX ID # / Medicare ID #:** |
| **PROVIDER ADDRESS:** |

## 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 Seeking Resolution Of A Billing DeterminationAppeal of Medical Necessity / Utilization Management Decision Contract Dispute Disputing Request For Reimbursement Of Overpayment Other: |

**\* DESCRIPTION OF DISPUTE:**

**EXPECTED OUTCOME:**

 **( )**

## Contact Name (please print) Title Phone Number

 **( )**

## Signature Date Fax Number

*For Health Plan/RBO Use Only*

TRACKING NUMBER PROV ID# CONTRACTED NON-CONTRACTED

] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

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**(Please do not staple)**

# PROVIDER DISPUTE RESOLUTION REQUEST

**(*For use with multiple “LIKE” claims*)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |
| **Last** | **First** |
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**(Please do not staple) Form Updated: 09/2013**