PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please fill out the form below. Fields marked with an asterisk (*) are required.
- Provide detailed information when filling out the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME sections.
- Include additional information to support the description of the dispute, but do not attach a copy of a previously processed claim.
- Multiple "LIKE" claims relate to the same provider and dispute but different members and service dates.
- For routine follow-ups, please utilize the Claims Follow-Up Form rather than the Provider Dispute Resolution Form.
- Mail the completed form to:

Star Medical Associates, a Medical Group, Inc.
PO Box 227
Burbank, CA 91503

***PROVIDERS NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

PROVIDER TYPE

☐ MD	☐ Mental Health Institutional	☐ DME	☐ Other
☐ Mental Health Professional	☐ Hospital	☐ Rehab	_____
	☐ ASC	☐ Home Health	_____
	☐ SNF	☐ Ambulance	(Specify 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: (* Require d for Claim, Billing, and Reimbursement of Overpayment Disputes)	**ORIGINAL CLAIM AMOUNT BILLED:**	**ORIGINAL CLAIM AMOUNT PAID:**

DISPUTE TYPE

☐ Claim	☐ Seeking Resolution of A Billing Determination
☐ Appeal 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**

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)
ICE Approved 10/5/07, effective 1/1/08

For Health Plan/RBO Use Only

TRACKING NUMBER_____PROV ID#_____

CONTRACTED_____ NON-CONTACTED_____

PROVIDER DISPUTE RESOLUTION REQUEST

For use with multiple "LIKE" claims (claims disputed for the same reason)

	*PATIENT NAME		DATE OF	*HEALTH PLAN ID	ORIGINAL CLAIM ID	*SERVICE FROM/TO
	LAST	FIRST	BIRTH	NUMBER	NUMBER	DATE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

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

ICE Approved 10/5/07, effective 1/1/08

Star Medical Associates, A Medical Group, Inc. | P.O. Box 227, Burbank, CA, 91503 | (818) 746-3616 | starhealthcaregroup.com