blue california | Promise Health Plan

PROVIDER DISPUTE RESOLUTION REQUEST FORM

- 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 and/or appeal. Do not include a copy of a claim that was previously processed.
- 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.

Mail the complete form(s) to:
Blue Shield of California Promise Health Plan
Attn: Provider Dispute Resolution Department
P.O. Box 3829
Montebello, CA 90640

***PROVIDER NAME:** ***PROVIDER TAX ID # / MEDICARE ID #:**

PROVIDER ADDRESS:

PROVIDER TYPE: ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance ☐ 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 A
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request for Reimbursement of Overpayment
☐ Seeking Resolution of a Billing Determination
☐ Contract Dispute
☐ Other: _____

***DESCRIPTION OF DISPUTE:**

For Health Plan Use Only
TRACKING NUMBER:
PROVIDER ID#:

EXPECTED OUTCOME:

Contact Name (please print) **Title** ( ) **Phone Number**

Signature **Date** ( ) **Fax Number**

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

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(For use with multiple "LIKE" claims)

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

#	*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									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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