

PROVIDER DISPUTE RESOLUTION REQUEST

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. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: UnitedHealthcare Community Plan – California
 Attention: Provider Dispute
 P.O. Box 31364
 Salt Lake City, UT 84131-0364

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

PROVIDER TYPE MD Mental Health Professional Mental Health Institutional Hospital ASC
 SNF DME Rehab Home Health Ambulance 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	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> 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 _____ PROVID# _____

CONTRACTED _____ NON-CONTRACTED _____

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

	* 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						
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)

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	PROVIDER ID or NPI#:
a. PROVIDER NAME:	b. CONTRACTED PROVIDER: ____ YES ____ NO
c. DATE DISPUTE RECEIVED (Date Stamped):	d. DATE OF INITIAL PAYMENT OR ACTION:
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) ____ YES ____ NO (If NO, should be returned to provider without action)	
f.1. DISPUTE TYPE: <input type="checkbox"/> CLAIM <input type="checkbox"/> APPEAL OF MEDICAL NECESSITY/UM DECISION <input type="checkbox"/> BILLING DETERMINATION <input type="checkbox"/> OVERPAYMENT DISPUTE <input type="checkbox"/> CONTRACT DISPUTE <input type="checkbox"/> OTHER _____ (Please specify type of "other")	
f.2. PROVIDER TYPE: <input type="checkbox"/> PROFESSIONAL <input type="checkbox"/> INSTITUTIONAL <input type="checkbox"/> OTHER	
g. DATE DISPUTE ACKNOWLEDGED:	h. TURNAROUND TIME (g – c):

TYPE OF LETTER SENT: (List the various ICE letters as applicable)

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	k. ACTION TURNAROUND TIME (j – c):	l. TYPE OF ACTION <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER
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IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	n. TURNAROUND TIME (m – c):	
o. DATE ADDITIONAL INFO RECEIVED:	p. RECEIPT TURNAROUND TIME (o – m):	
q. DATE OF ACTION:	r. ACTION TURNAROUND TIME (q – o):	s. TYPE OF ACTION <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:
