PROVIDER DISPUTE RESOLUTION REQUEST

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

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 claims that was previously processed
- For routine claim follow-up, please call the client specific telephone number on the member's identification card or 1(866) 501-0777 instead of using the Provider Dispute Resolution Form.
- Mail the completed form to: **ValueOptions® of California, Inc.**
Provider Dispute Resolution Department
P.O. Box 6065
Cypress, CA 90630

* Provider Name:	*Provider Tax ID #
*Provider Address:	

PROVIDER TYPE: ☐ MD ☐ PhD ☐ LCSW ☐ MFT ☐ Facility ☐ Other________________________ (Please specify type of "other")

DISPUTE INFORMATION: ☐ Single ☐ Multiple "LIKE" Claims/Disputes (complete attached spreadsheet) Number of claims/disputes:____________

* Patient Name:		Date of Birth:
Member ID Number:	Employer Name:	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
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request for Reimbursement of Overpayment
☐ Seeking Resolution of a Billing Determination
☐ Contract Dispute
☐ Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

______________________________ _ ____________________ __________________

Contact Name (please print) Title Phone Number

______________________________ __ __________________ __________________

Signature Date Fax Number

[ ] Check Here if Additional Information is Attached

For Health Plan Use Only

Tracking Number________

Provider ID#____________