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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. Include a copy of a claim that was previously processed.

Mail the complete form(s) to:
Blue Shield of California Promise Health Plan
FirstSource PHP PDR
265 Airpark Blvd Ste 100
Chico, CA 95973

***PROVIDER NAME:** ***PROVIDER TAX 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)

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.

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PROVIDER DISPUTE RESOLUTION REQUEST

(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)