Provider Dispute Resolution Request

Provider Name:		Provider Tax ID #:
Provider Address:		Contracted? ☐ Yes ☐ No
Patient Name:		Date of Birth:
Social Security #:	Subscriber ID #:	Claim #:
Service "From – To" Date:	Original Billed Amount:	Claim Amount Paid:

Claim Information: ☐ Single Claim ☐ Multiple "LIKE" claims (attach spreadsheet)

Dispute Type: ☐ Claim ☐ Appeal of Medical Necessity ☐ Contract Dispute ☐ Seeking Resolution of a Billing Determination ☐ Disputing a Request for Reimbursement of Overpayment ☐ Other

Description of Dispute: (INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND BASIS THEREFOR) Additional paper can be attached if necessary

Expected Outcome: (please provide by claim if multiple)

Contact Name (Print) _____ Title _____ Area code & Phone # _____

Signature and Date _____ Email Address _____ Fax # _____

Send to: Community Care Health Plan Customer Service/ Appeals
P.O. Box 45026, Fresno, CA 93718
Or
Fax to: (559) 599-0022