Provider Dispute Resolution Request

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

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

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

Description of Dispute: (Indicate the reason for the dispute and the Provider's position. Additional paper can be attached if needed)

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 Customer Service/Provider Disputes
P.O. Box 45026, Fresno, CA 93718
Or
Fax to: (559) 599-0022