



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.
- Mail the completed form to:

Connected Senior Care Advantage
Attn: Appeals Dept.
P.O. Box 70021
Anaheim, CA 92825

 OR

• Fax the completed form to:
512-872-6908

*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

<i>For Health Plan/RBO Use Only</i>	
TRACKING NUMBER _____	PROV ID# _____
CONTRACTED _____	NON-CONTRACTED _____

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Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

	* 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								