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 include a copy of the claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Jade Health Care Medical Group
  445 Grant Avenue, Suite 700
  San Francisco, CA 94108
  ATTN: Provider Dispute Resolution (Fax# 415-955-8815)

***PROVIDER NAME:**	***PROVIDER TAX ID # / Medicare ID #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ 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

☐ 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**
(Please do not staple additional information)

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

T-6

PROVIDER DISPUTE RESOLUTION REQUEST

For use with multiple "LIKE" claims (claims disputed for the same reason)

Provider:

RE: "Like" Claim Disputes for Tracking #

Number	*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							