

## 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 not include a copy of a 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: Marin IPA Attn: Provider Dispute Resolution Intake Coordinator  
3 Hamilton Landing, Suite 160  
Novato, CA 94949

<b>*PROVIDER NAME:</b>	<b>*PROVIDER TAX ID#/Medicare ID#:</b>
<b>PROVIDER ADDRESS:</b>	

**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:* \_\_\_\_

<b>*Patient Name:</b>		<b>Date of Birth:</b>
<b>*Health Plan ID Number:</b>	<b>Patient Account Number:</b>	<b>Original Claim ID Number:</b> (If multiple claims, use attached spreadsheet)
<b>Service "From/To" Date:</b> (* Required for Claim, Billing, and Reimbursement of Overpayment Disputes)	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>

**DISPUTE TYPE**

<input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity/Utilization Management Decision <input type="checkbox"/> Request for Reimbursement of Overpayment	<input type="checkbox"/> Seeking Resolution of a Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Other:
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**\*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#