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: Meritage Medical Network Attn: Provider Dispute Resolution Intake Coordinator
  2100 S. McDowell Blvd.
  Petaluma, CA 94954

*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 ❑ Singe ❑ 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#