



HMO
UnitedHealthcare of California
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.

Mail the completed form to:
Provider Dispute Resolution HMO
PO Box 30764
Salt Lake City, UT 84130-0764

*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:
* Member's 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	E-Mail Address	Fax Number

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)