PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.

INSTRUCTIONS

• Please complete the below form. Fields with an asterisk (*) are required. For the online editable form, use the tab key to move from field to field. Use the spacebar to check the appropriate boxes.
• Please complete this form if you are seeking reconsideration of a previous billing determination.
• 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.
• In order to ensure the integrity of the Provider Dispute Resolution (PDR) process, we will re-categorize issues sent to us on a PDR form which are not true provider disputes (e.g., claims check tracers or a provider’s submission of medical records after payment was denied due to a lack of documentation).
• For routine follow-up, use Secure Messaging. You can send online questions to Availity Web Portal at www.availity.com
• Mail the completed form to: Anthem Blue Cross
  P. O. Box 60007
  Los Angeles, CA 90060-0007

*PROVIDER NAME:  *PROVIDER NPI #:

PROVIDER ADDRESS:

PROVIDER TYPE  □ MD  □ Mental Health  □ Hospital  □ ASC  □ SNF  □ DME  □ Rehab
□ Home Health  □ Ambulance  □ Other ____________________________
(please specify type of “other”)

* CLAIM INFORMATION  □ Single  □ Substantially Similar Multiple Claims (complete attached spreadsheet)

* 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  □ Seeking Resolution Of A Previous Billing Determination
□ Appeal of Medical Necessity / Utilization Management Decision  □ Contract Dispute
□ Request For Reimbursement Of Overpayment  □ 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)

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Revised May 2014
PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple “LIKE” claims (disputed for the same reason)

*PROVIDER NAME:  

*PROVIDER NPI #:  

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<th>* Service From/To Date</th>
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