Provider Dispute Resolution Request

INSTRUCTIONS
Please fully complete the form below. 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. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service. For routine follow-up, please use the Claims Follow-Up Form instead of this Provider Dispute Resolution Form.

Mail to: MediExcel Health Plan, 750 Medical Center Court Suite #2, Chula Vista, CA 91911
Attention: Provider Dispute Resolution

Questions: 916.421.1659

PROVIDER INFORMATION

*Provide Name _____

Address _____ Suite # _____

City, State, Zip _____ Phone # _____

*Provider NPI# _____ Provider Tax ID # _____

Provider Type ☐ MD ☐ Mental Health Professional ☐ Mental Health Institution ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab

CLAIM INFORMATION

☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) Number of Claims _____

*Patient Name _____ *Date of Birth _____

*Health Plan ID# _____ Patient Account # _____ Original Claim ID# _____
(If multiple, use spreadsheet)

Service "From/To" Date: (*Required for Claim, Billing & Reimbursement of Overpayment Disputes) _____

Original Claim Amount Billed _____ Original Claim Amount Paid _____

Dispute Type ☐ Claim ☐ Appeal of Medical Necessity/Utilization Management Decision
☐ Seeking Resolution of a Billing Determination ☐ Contract Dispute
☐ Disputing Request for Reimbursement or Overpayment ☐ Other _____

*Description of Dispute _____

*Expected Outcome _____

Print Name _____ Title _____

Signature _____ Date _____

Phone _____ Fax _____

☐ Check here if additional information is attached (please do NOT staple)

OFFICE USE ONLY **Tracking #** _____ **Prov. ID#** _____ Contracted ☐ Yes ☐ No

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TRACKING FORM for optional use by health plan/delegated provider

MediExcel HEALTH PLAN

INSTRUCTIONS

This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution. The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

a. Provider Name _____ b. Contracted Provider ☐ Yes ☐ No

c. Date Dispute Received (Date Stamped) _____ d. Date of Initial Payment or Action _____

e. Was Dispute Received Within Timeframe? (c-d) ☐ Yes ☐ No (If No, should be returned to provider without action)

f.1 Dispute Type ☐ Claim ☐ Appeal of Medical Necessity/UM Decision ☐ Billing Determination ☐ Overpayment Dispute

☐ Contract Dispute ☐ Other (Please specify) _____

f.2 Provider Type ☐ Professional ☐ Institutional ☐ Other

g. Date Dispute Acknowledged _____ h. Turnaround Time (g-c) _____

TYPE OF LETTER SENT List the various ICE letters as applicable

If no additional information requested:

j. Date of Action _____ k. Action Turnaround Time (j-c) _____ i. Type of Action ☐ Upheld ☐ Overturned ☐ Other

If additional information requested:

m. Date of Additional Info Requested _____ n. Turnaround Time (m-c) _____

o. Date of Additional Info Received _____ p. Receipt Turnaround Time (o-c) _____

q. Date of Action _____ r. Action Turnaround Time (q-o)_____ Type of Action ☐ Upheld ☐ Overturned ☐ Other

Complete description of determination rationale _____