



PROVIDER DISPUTE RESOLUTION REQUEST

By submitting this form, I agree not to bill the member(s) named on it.
Initial here and sign at bottom of form: _____

INSTRUCTIONS

- **For routine follow-up**, please contact Health Plan of San Mateo's Claims Department at (650) 616-2056.
- **To request dispute resolution**, please 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. You do not need to include a copy of a claim that was previously processed.
- **Fax** the front and the back of the completed form to **(650) 829-2051** or **mail** it to:
Attn: Provider Disputes
Health Plan of San Mateo
701 Gateway Boulevard, Suite 400
South San Francisco, CA 94080

*Provider Name:		*NPI #:	
Provider Address:			
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other (please specify):			
Line of Business: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> HealthWorx		<input type="checkbox"/> CareAdvantage <input type="checkbox"/> ACE <input type="checkbox"/> Healthy Families <input type="checkbox"/> Healthy Kids	
		<input type="checkbox"/> Contracted <input type="checkbox"/> Non-Contracted (<i>see back of form, for CareAdvantage only</i>)	

*Claim Information Single Multiple "like" claims (complete a Supplemental Form) Total number of claims: _____

*Member Name		Date of Birth:	
*Member ID Number:		Original Claim ID Number (if multiple claims, use attached spreadsheet):	
Service "From/To" Dates <i>*Required for Claim, Billing, and Reimbursement of Overpayment Disputes</i>		Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type	<input type="checkbox"/> Denied Claim	<input type="checkbox"/> Underpayment of a Claim	<input type="checkbox"/> Request for Reimbursement of Overpayment
	<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute	
	<input type="checkbox"/> Other (please specify):		

* Description of Dispute (continue on back if needed):

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 #:	Provider ID #:
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HEALTH PLAN OF SAN MATEO PROVIDER DISPUTE RESOLUTION REQUEST (SIDE 2)

I am NOT a CareAdvantage Contracted Provider. *(Please complete and sign the waiver below.)*

I am a Contracted Provider. *(Please disregard the waiver.)*

**HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT**

Member Name

Member ID / Member HIC Number

Provider Name

Dates of Service

Health Plan of San Mateo

Health Plan

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date

H5428_CA_3070_08 (approved 02/08/2008)

Description of Dispute (continued)

For Health Plan Use Only: Tracking #:

Provider ID #: