HealthPlan OF SAN MATEO

Provider Dispute Resolution Request

By submitting this form, I agree not to bill the member(s) named on it.

Initial or check 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
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

*Provider Name: NPI #

Address:

City: State Zip Code

Provider Type: ◯ PCP ◯ Specialist ◯ Hospital ◯ ASC ◯ SNF ◯ DME
◯ Rehab ◯ Home Health ◯ Ambulance ◯ Other (please specify): _____

Line of Business: ◯ ACE ◯ CareAdvantage ◯ Healthy Families ◯ HealthWorx ◯ Healthy Kids ◯ Medi-Cal

◯ Contracted ◯ Non-Contracted
(See back of form, for CareAdvantage only)

* 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(s):

Service "From/To" Dates: to Original Claim Amount Billed:

** Required for Claim, Billing, and Reimbursement of Overpayment Disputes*

Original Claim Amount Paid:

Dispute Type
☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Contract Dispute ☐ Denied Claim
☐ Request for Reimbursement of Overpayment ☐ Underpayment of a Claim
☐ Other (please specify):

*Description of Dispute (continue on page 2 if needed).

Expected Outcome

Contact Title Phone

Signature Date Fax

☐ Check here if additional information is attached. (Please do not staple additional information.)

For Health Plan Use Only: Tracking #: Provider ID #:

☐ 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

H542_CA_3070_08 (approved 02/08/2008)

Description of Dispute (continued from Page 1)

Print Form