Provider Dispute Resolution Request

Community Health Plan of Imperial Valley (CHPIV)

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- 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.
- For routine follow-up status, please call 888-893-1569.
- Mail the completed form to the following address.

  Community Health Plan of Imperial Valley Provider Disputes and Appeals Unit
  PO Box 989881
  West Sacramento, CA 95798-9881

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:		Date of birth:
*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

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

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

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Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

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23-610 (7/23)