



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, please use the Claims Follow-Up Form.
- 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

<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Previous Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Request For Reimbursement Of Overpayment	<input type="checkbox"/> 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)

<i>For Health Plan Use Only</i>
TRACKING NUMBER
PROVIDER ID#



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For use with multiple “LIKE” claims (disputed for the same reason)

*PROVIDER NAME:	*PROVIDER NPI #:
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Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim 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									
13									
14									
15									

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
 (Please do not staple additional information)

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