



PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. 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. Including a copy of the Explanation of Benefits (EOB) will help to expedite resolution.
- Mail the completed form to: **Sharp Community Medical Group
Provider Dispute Resolutions
P.O. Box 939034
San Diego, CA 92193**

***PROVIDER NAME:**

***PROVIDER TAX ID #:**

***PROVIDER ADDRESS FOR RESPONSE:**

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance ☐ Other _____
(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:**

Patient Account Number:

***Original Claim Number:** (If multiple claims, use attached spreadsheet), **or Original Referral Number:**

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)

Original Claim Amount Billed:

Original Claim Amount Paid:

*DISPUTE TYPE

- | | |
|--|--|
| ☐ Claim | ☐ Seeking Resolution Of A Billing Determination |
| ☐ Appeal of Medical Necessity / Utilization Management Decision | ☐ Contract Dispute |
| ☐ Request For Reimbursement Of Overpayment | ☐ Other (describe): |

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

***Contact Name (please print)**

Title

***Phone Number**

Signature

Date

Fax Number

For SCMG Use Only

CSR NUMBER

Provider (Vendor) ID#

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED



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(For use with multiple “LIKE” claims)

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									

