Sharp Rees-Stealy Medical Group
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. Including a copy of the Explanation of Benefits (EOB) will help to expedite resolution.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Sharp Rees-Stealy Medical Group
  P.O. Box 939035
  San Diego, CA 92193
  Att: Provider Dispute Resolution Unit

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

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

***Contact Name (please print)**	**Title**	( ) ***Phone Number**
Signature	**Date**	( ) **Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

For SRS Use Only
CSR NUMBER
Provider (Vendor) ID#

Sharp Rees-Stealy Medical Group
PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

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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**