Health Net

PROVIDER DISPUTE RESOLUTION REQUEST

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.
- For routine follow-up, use the Provider Inquiry Request form instead of this form.

Mail the completed form to the following addresses. Please note the specific address for all Medi-Cal appeals.

Health Net Provider Appeals Unit
P.O. Box 10406 Van Nuys, Ca 91410-0406
(800) 641-7761 or go to our Web site: www.healthnet.com

Health Net Medi-Cal Provider Appeals Unit
11971 Foundation Place Rancho Cordova, Ca 95670
Medi-Cal Provider Services (800) 675-6110

For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

*PROVIDER NAME:	*PROVIDER TAX ID #:
PROVIDER ADDRESS:	**Contracted : Y/N (pls. circle)**

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:
*Social Security Number :	*Subscriber ID/ CIN Number:	* Original Claim 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 BASIS THEREFORE:** (Additional paper can be attached if necessary)

*** EXPECTED OUTCOME: (please provide by claim if multiple)**

Contact Name (please print)	Title	( ) Area code & Phone Number
Signature and date	Email Address	( ) Area code & Fax Number

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

For Health Plan Use Only:
Case #_____
Provider #_____

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INSTRUCTIONS: (For use with multiple "Like" claims only)

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Number	* Patient Name		Date of Birth	* Subscriber ID No./ CIN 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									

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