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.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: California Provider Dispute Resolution Request

Cigna Network
P.O. Box 188011
Chattanooga, TN 37422

GWH - Cigna Network
P.O. Box 668
Kennett, MO 63857

*Provider NPI	Provider Tax ID

*Provider Name

Provider Address

PROVIDER TYPE:

☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME
☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other (please specify type): _____

CLAIM INFORMATION:

☐ Single ☐ Multiple **"LIKE"** Claims (Complete attached spreadsheet) Number of Claims: _____

*Patient Last Name (First) (MI)	Date of Birth

*Health Plan ID Number	Patient Account Number	Original Claim ID Number (If multiple claims, use attached spreadsheet)

*Service Dates: (Required for Claim, Billing and Reimbursement of Overpayment Disputes) From: _____ To: _____	Original Claim Amount Billed	Original Claim Amount Paid

DISPUTE TYPE:

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request for Reimbursement of Overpayment
☐ Seeking Resolution of a Billing Determination
☐ Contract Dispute
☐ 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)

For Health Plan/RBO Use Only
TRACKING NUMBER: _____ PROV ID # _____
CONTRACTED ____ NON-CONTRACTED ____

865557 05/2013