PROVIDER DISPUTE RESOLUTION REQUEST

By submitting this form, I agree not to bill the member(s) named on it.

***Initial here and sign at bottom of form*: __________**

INSTRUCTIONS

- **For routine follow-up,** please contact Health Plan of San Mateo's Claims Department at (650) 616-2056.
- **To request dispute resolution**, please complete the form below. **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. You do not need to include a copy of a claim that was previously processed.
- **Fax** the front and the back of the completed form to **(650) 829-2051** or **mail** it to:
  Attn: Provider Disputes
  Health Plan of San Mateo
  701 Gateway Boulevard, Suite 400
  South San Francisco, CA 94080

*Provider Name:	*NPI #:
Provider Address:	
Provider Type: ☐ PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other (please specify):	
Line of Business: ☐ Medi-Cal ☐ CareAdvantage ☐ Healthy Families ☐ HealthWorx ☐ ACE ☐ Healthy Kids	☐ Contracted ☐ Non-Contracted ***(see back of form, for CareAdvantage only)***

*Claim Information ☐ Single ☐ Multiple "like" claims (complete a Supplemental Form) *Total number of claims:* ______

*Member Name		Date of Birth:
*Member ID Number:	Original Claim ID Number (if multiple claims, use attached spreadsheet):	
Service "From/To" Dates **Required for Claim, Billing, and Reimbursement of Overpayment Disputes*	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type ☐ Denied Claim ☐ Underpayment of a Claim ☐ Request for Reimbursement of Overpayment
☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Contract Dispute
☐ Other (please specify):

* Description of Dispute (continue on back if needed):

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.)*

For Health Plan Use Only: Tracking #: Provider ID #:

HEALTH PLAN OF SAN MATEO PROVIDER DISPUTE RESOLUTION REQUEST (SIDE 2)

☐ **I am NOT a CareAdvantage Contracted Provider.** ***(Please complete and sign the waiver below.)***

☐ **I am a Contracted Provider.** ***(Please disregard the waiver.)***

HEALTH PLAN OF SAN MATEO
WAIVER OF LIABILITY STATEMENT

Member Name	Member ID / Member HIC Number
Provider Name	Dates of Service
Health Plan of San Mateo Health Plan	

As a provider of the mentioned member(s) , I hereby waive any right to collect payment from the mentioned member(s) for the mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date

H5428_CA_3070_08 (approved 02/08/2008)

Description of Dispute (continued)

For Health Plan Use Only: Tracking #: Provider ID #: